PART 2 - CLAIMS

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

LIST OF CHAPTERS

2-0100 INTRODUCTION

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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

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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

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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

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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

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***(ENTIRE CHAPTER REISSUED 09/09, TRANSMITTAL 09-06)**

2-0401-1 Purpose and Scope

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

2-0401-2 Responsibilities

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

2-0401-3 System Components

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

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

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

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

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 created in the Case Management System and an acknowledgement to the agency and the claimant is generated automatically. The system controls number assignments and edits entries for duplication of date and other identifiable errors.

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

c. Reminders may be set, allowing CEs to diary cases for further review and action.

d. Responsible Claims Examiner (RCE) is shown in the Case Management System. This shows who is currently managing the case.

e. Incoming and pending mail may be viewed in the imaged case file. Priority correspondence is tracked in the system and assigned automatically for some correspondence types or upon review as assigned by the CE.

f. Reports can be produced by managers and CEs using the automated reporting system. These reports are used to query pending cases in need of action and for case management purposes.

g. Addresses for frequent correspondents other than the claimant or beneficiary are maintained in the Case Management System. Entry of names and addresses of

authorized attorneys and other legal representatives is required; entry of other names and addresses is optional. By entry of these addresses into the system, the CE is able to pull them into correspondence as needed.

2-0401-5 Status Changes

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

2-0401-6 Definitions of Adjudication Status Codes

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

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

Acceptances

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

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

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

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

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

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

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

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

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

DO: Disallowed pending.

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

D2: Denied; claimant not a civil employee.

D3: Denied; fact of injury not established.

D4: Denied; not in performance of duty.

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

D7: Remanded by ECAB.

D8: Remanded by H&R.

D9: Request for reconsideration pending.

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

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. There are nineteen (19) two-character pay status codes in the system. Only certain codes are compatible with payment through the Compensation Management System and allow for bill payment. Brief definitions are indicated below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CL: Administrative closure.

RT: Retired or awaiting retirement.

2-0401-8 Assignment of Status Codes

8. Assignment of Status Codes. Rules for assigning status codes to cases as they pass

through the system will be given at appropriate points in the case development and case management chapters of the Procedure Manual. So that this information is available in summary form, and its relationship to information tracked by reports is clear, a brief account of proper code assignment in developing and adjudicating cases is given here.

a. Primary Adjudication.

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

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

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

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

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

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

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

AC/MC: Condition accepted as injury-related. Continued pay was elected and is supported for some period. Further bills expected 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 a condition or formal denial, as well as appropriate status codes entered into the case management system.

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

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

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

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

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

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

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

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

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

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

b. Compensation Payment.

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

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

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

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

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

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

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

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

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

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

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

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

c. Denials.

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

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

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

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

The use of these codes will enable 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 via retirement (AM/MC).

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

d. Reconsideration, Hearings, Appeal. Code D7 or D8 is used when a remanded case is not in a payment status and a de novo decision has not

been issued. The pay status is UD. D9 is used while an application for reconsideration on a denied case is being processed. Cases in pay status (LWEC, SA) which are remanded or under reconsideration will retain the adjudication and pay status appropriate to their benefit status (e.g. AP/PW).

e. Reopening Closed Cases.

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

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

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

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

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

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

2-0401-9 Inquiries

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

2-0401-10 ICD-9 Codes

10. ICD-9 Codes. When conditions are accepted as work-related, the CE should enter the corresponding ICD-9 codes into the case management system. The codes are found in the ICD-9 manuals or electronic ICD-9 reference material. As additional conditions are accepted, the ICD-9 codes should be added to the system.

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. Coding should be as specific as possible, coded to the 4th or 5th digit.

b. Surgery. When a surgical procedure has been accepted as work-related, the CE should ensure that the accepted condition has been upgraded, when necessary, to ensure that bills will be paid appropriately.

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.

d. Specific Identifiers. One-character identifiers unique to the case management system are used to add more specificity to ICD-9 codes. These identifiers are:

R Right
L Left
B Both
A Aggravation

2-0402 SECURITY & PREVENTION OF FRAUD & ABUSE

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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 CONFERENCES

TABLE OF CONTENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Give the participant a clear picture of the purpose of the conference call.

b. Explain the issues to be discussed.

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

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

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

a. Identification of caller.

b. Statement of the purpose of the call.

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

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

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

7. Senior CE/GS-12 CE Actions. During the discussion, the SrCE/GS-12 CE should:

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

b. Take notes complete enough to capture necessary information.

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

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

8. Memorandum of Conference. After a formal conference is completed, the SrCE/GS-12 CE should complete a neutral Memorandum of Conference (that is, one which does not contain findings). It should describe what each party said in the conference in clear, non-technical language. The Memorandum of Conference should:

a. Include the name of the claimant, file number, and date of the conference.

b. Identify the SrCE/GS-12 CE who conducted the conference and the participants in the conference.

c. Provide a background.

d. Identify and describe the issues which were discussed.

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

f. Describe the explanations provided in the conference to properly document the record. The SrCE/GS-12 CE should explain, in clear language, the criteria being used to make the various decisions and the implications of those decisions.

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

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

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

i. Describe any agreements reached in the conference. For example, an agreement with a claimant in an overpayment case to repay with deductions from schedule award payments.

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

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

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

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

b. Comments Not Required. When it is clear that the decision will benefit the claimant and that the basis of any objection from the employing agency will be

addressed in the ensuing decision or other correspondence, a comment period is not required. For instance, a controverted case which will be resolved in the claimant's favor as a result of a conference, and the employing agency's controversion will be addressed via correspondence which will advise the agency of the basis for continuing pay.

2-0600 DISABILITY MANAGEMENT

Chapter 2-600, Disability Management

2-600-1 Purpose and Scope.

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

2-600-2 Introduction

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

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

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

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

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

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

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

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

(3) Customer Service.

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

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

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

(1) Medical intervention includes the following:

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

Questions to the attending physician. The CE may write case-specific questions to the attending physician to obtain information about the

claimant's condition, the anticipated period of disability, work capacity, and the physician's treatment plan.

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

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

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

(2) Nurse intervention includes the following:

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

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

(3) Vocational Rehabilitation intervention includes the following:

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

Medical Rehabilitation. If permanent work restrictions are not yet on file, the case may still be referred for Medical Rehabilitation for work hardening programs and functional capacity evaluations aimed at producing work tolerance limitations. A referral may also be appropriate for speech therapy, orthotics, or prosthetics which would make the injured worker more

employable; or psychiatric counseling, drug addiction counseling, or pain management clinics which would likely improve the claimant's condition with a view towards return to work.

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

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

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

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

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

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

If the case cannot be accepted on initial review, tailored development outlining the deficiencies in the case should be undertaken immediately. While 30 days should be provided for the submission of evidence, the case can and should be accepted as soon as sufficient evidence is received. Before a case is denied, the full 30-day period for submission of evidence is required; however, the OWCP should make every effort to issue acceptance decisions on these claims as soon as possible so that medical treatment and disability management can commence.

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

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

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

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

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

b. Periodic Roll. When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation should usually be paid on the periodic roll.

6. Customer Service and Communication. Effective and efficient communication throughout the life of a case is very important, but during the disability management phase it is crucial. In the course of managing a disability claim, the CE is responsible for communicating case management goals to the claimant, EA, attending physician, and others involved in a case so that each is aware of his or her responsibilities. The CE should also work with them to address and resolve issues hindering return to work. Intervention strategies with the Nurses, Rehabilitation Specialist and Rehabilitation Counselor, EA, and claimant are outlined in detail later in this chapter.

Routine customer service is equally as important as targeted intervention.

a. Phone Calls. Returning calls to all parties promptly is necessary so that outstanding issues can be addressed. The CE should attempt to return calls as quickly as possible in these cases because good communication is integral to effective early disability management. **All calls should be documented in the case file.**

b. Response Mail. Responding to written inquiries in a timely and efficient manner allows pending issues to be addressed so that the return-to-work effort can continue. Sometimes, especially if the claimant or EA seem uncertain of the status of the case or a recent action, a phone call in response to a written inquiry may be more helpful than a written response. A phone call allows the parties involved to discuss any areas of concern. Depending on the issue, a conference may also be beneficial. (Conferences are discussed later in this chapter.)

7. Medical Intervention. The goal of medical intervention in disability cases is to address and resolve medical issues to assist the claimant with recovery and return to work. The CE is responsible for authorizing appropriate treatment for the accepted conditions, clarifying medical issues, obtaining information about work capacity, and taking other intervention actions as needed to address medical issues impeding recovery and return to work. Developing and evaluating medical evidence is discussed in detail in PM Chapter 2-0810.

a. Initial Contact with the Attending Physician. When the initial period of compensation entitlement is established, the CE should review the medical evidence to determine the expected period of disability. Initial intervention action should be taken consistent with the information provided by the attending physician (AP). A letter to the AP could be one of the CE's first steps in the disability management of a case. Not only will this letter to the AP be used to gather information, it will also set the tone for working with this medical provider moving forward.

If the relationship between the mechanism of injury and resulting accepted condition(s) is very clear and the AP has been treating the claimant since the date of injury, it is not always necessary to provide a Statement of Accepted Facts (SOAF) to the AP with the initial inquiry. However, if either of these criteria is not met in a particular case, or the case is complex factually or medically, the CE may provide a SOAF for the physician to use as the framework for responding to questions posed.

The initial letter to the AP should outline the accepted conditions in the case and seek responses to relevant issues, such as:

- The status of the claimant's recovery from the injury.
- An update on the claimant's post-operative condition, if applicable.
- The specifics of the treatment plan.
- Projected date of return to work with and without restrictions.
- Prognosis for full recovery.

The CE should be careful not to ask questions that are not germane to the case. For instance, if the claimant just had a spinal fusion one week ago, it would be inappropriate to ask whether the claimant's condition has now resolved. On the other hand, if the claimant only suffered a minor sprain eight weeks ago, asking whether the condition has completely resolved would be appropriate.

b. Clarifying medical issues. Not only at the onset of disability, but also throughout the course of a disability case, it will be necessary for the CE to request clarification of medical issues such as the anticipated length of disability, new diagnoses, the treatment plan, recommendations for work restrictions or other

medical issues. In addition, the claimant may encounter delays in recovery or obstacles to obtaining a release for work.

(1) Common examples of issues that would require clarification through medical intervention include:

- The physician estimates a length of disability longer than usual for the injury or condition, without medical justification.
- Disability extends beyond the date the physician originally projected, and no explanation is provided.
- The medical evidence no longer supports continued total disability, but the claimant has not been released to any type of light duty or full employment.
- Temporary restrictions have continued beyond the usual duration for the accepted condition.
- The restrictions provided are of a greater severity than would normally be expected for the accepted condition.
- The claimant develops a non-work related condition which may affect the time needed to recover from the work-related condition.

(2) When a delay or obstacle is encountered, or a medical issue needs to be clarified, the CE should initiate medical intervention. Depending on the circumstances in the case, the intervention may include the following:

- Questions to the AP. The CE could write to the AP and ask specific questions to obtain the information needed to resolve medical issues. The CE may pose questions about the treatment plan, the reasons for the length of disability, whether a return to regular duty will be likely, and recommendations for work restrictions. Just like the initial contact with the AP, the CE should tailor the questions to the specific circumstances of the case and not ask questions that are not relevant to the case.
- Review by the District Medical Advisor (DMA). When the CE needs assistance with interpretation of medical reports, information about general medical issues related to a case, or review of the appropriateness of medical authorizations, the DMA can be asked to review the case and provide an opinion to assist the CE with the medical management of a case.
- Second opinion referrals. Medical evaluations from a second opinion physician may be requested at any time. If the attempt to obtain information from the AP is unsuccessful, the CE should refer the case for a

second opinion. Second opinions are also useful throughout the course of a case for obtaining additional information about the claimant's condition and work capacity. The authority for second opinion medical examinations is found at 5 U.S.C. 8123(a).

- Referee examinations. When a conflict of medical opinion arises between the AP and an OWCP-appointed physician such as a second opinion referral specialist or the DMA, and the opinions are of equal weight, the CE must arrange for a referee medical examination to resolve the conflict of opinion. The authority for referee medical examinations is also found at 5 U.S.C. 8123(a).

c. Recurring Medical Intervention. When an action is taken, the CE should review the outcome of the intervention to determine whether the issue has been resolved and whether medical recovery and return-to-work efforts are progressing appropriately. If the medical intervention does not clarify or resolve the issue, the CE should undertake further intervention.

Timely, specific, and ongoing intervention to address and resolve medical issues is essential to helping the claimant recover and return to work as quickly as possible. The CE may need to use all of the medical intervention techniques described above at various times during the disability management of one case.

In order to facilitate the best outcome, the CE should advise the FN or RS of the weight of medical evidence regarding work capacity, should the outcome of medical intervention actions change this determination. The claimant and EA should be kept abreast of the CE's ongoing actions in this regard.

d. Authorization for medical treatment. Beyond specifically targeted medical intervention, the CE should also review and respond promptly when requests for authorization of medical treatment are received to ensure treatment is not delayed. Authorizing medical treatment quickly allows medical recovery to progress. The CE may receive formal requests for authorization but may also learn of pending medical requests via updates from the FN or while reviewing new mail.

(1) When clarification is needed regarding an authorization request, the CE should request clarification from the AP, consult the DMA, or refer the case for a second opinion examination. Appropriate medical development should be undertaken in a timely manner so that the treatment authorization issue can be resolved and the case can move forward.

(2) Requests for surgery. If the AP requests authorization for surgery, the CE should ensure that medical rationale has been provided to establish that the proposed surgery is appropriate for the accepted condition(s). If appropriate, the case should be sent to the DMA for review prior to authorization. See PM Chapter 2-0810.

If the surgery is authorized, the CE should ensure that ICD-9 codes for the accepted conditions are updated if necessary. The CE should also request the surgery date and expected period of disability from the AP, as this information is necessary to medically manage the case.

8. Nurse Intervention. The Nurse Intervention program was implemented to assist CEs with medical management of disability claims and to provide claimants with assistance in coordinating medical care. The goal of Nurse Intervention is medical recovery for the claimant and early return to work.

The Nurse Intervention program is comprised of a Staff Nurse, who is located in the district office, and COP Nurses and Field Nurses, who work on a contractual basis in the district office's servicing area. The CE, however, is responsible for the management and overall direction of the case. Nurse Intervention is discussed in more detail in PM Chapter 2-0811.

a. The Role of Nurses.

(1) Staff Nurse (SN). The SN plays an important role in the Nurse Intervention process. The SN's responsibilities include, but are not limited, to the following:

- Ensuring there is a sufficient number of CNs and FNs to service the district office's needs.
- Monitoring of the nurse's performance in correlation to both the contract specifications and the quality of services provided.
- Assigning CNs and FNs in particular cases.
- Reviewing nurse reports for completeness and timeliness prior to authorizing payment of bills.
- Communicating with the CEs regarding the cases assigned to FNs.
- Relaying important or time-sensitive information to the CEs so that action can be taken if needed, e.g. if expedited adjudication is needed.

(2) COP Nurse (CN). The CN is a registered nurse who is assigned early in the life of a traumatic injury case and works each case telephonically rather than in person. The information obtained is then used to make decisions about the best path for that particular case. The CN's responsibilities include, but are not limited to, the following:

- Contacting the claimant to obtain a history of injury, history of treatment, and current work status, as well as physician contact information.
- Confirming the work status with the EA and ascertaining whether accommodations are available if needed.
- Contacting the physician's office to obtain a verbal history of treatment and expected treatment plan. He or she can also provide the OWCP

address for submission of reports and contact information for requesting medical authorizations should the claim be approved.

(3) Field Nurse (FN). The FN is a registered nurse who assists in the management of disability claims in a number of ways. Unlike the CN, the FN's contact is frequently in person with the claimant, EA, and medical

providers. The FN's responsibilities include, but are not limited to, the following:

- Developing a rapport with the claimant and answering questions about what to expect from OWCP, while at the same time establishing the return-to-work goal clearly for the claimant from the outset.

- Making determinations about the initial extent of the injury, treatment necessary for recovery, and return-to-work expectations (using the CN's report, if available, as part of this process).

- Attending the claimant's medical appointments to facilitate communication about return to work and ease any authorization difficulties the claimant may be encountering.

- Obtaining functional capacities, restrictions and limitations from the physician as early as possible, and then providing these to the EA.

- Identifying possible barriers to the claimant's return to work and then developing a plan of action with the CE to resolve the identified barriers.

- Continual evaluation of the likelihood of return to work with the EA and physician, with the goal of following the plan through to successful full duty return to work and closure.

- Communicating regularly with the medical providers, claimant, EA, SN and CE to keep all parties informed of the status of the case to facilitate a timely, sustainable return to work.

- Making recommendations for vocational rehabilitation when necessary.

Usually a FN's contact with the claimant, EA and physician is in person. Sometimes though, contact may be only telephonic in nature. This may occur, for instance, if there is no available FN in the claimant's locale. This may also occur in non-complex cases where telephonic intervention is determined to be sufficient. Regardless of whether the communication is in person or telephonic, the nurses in these cases are referred to as FNs, since the goal of the intervention is the same.

b. COP Nurse Assignments. Although nurse intervention will not be extensive

during the COP period, the medical knowledge and experience of a CN will permit identification of cases that require more extensive intervention due to the severity of the injuries, contemplated surgical intervention, or lost time from work.

Based on the data entered when a traumatic injury case is created (particularly date stopped work), a case will become automatically eligible for a CN assignment if the claimant does not return to work. This happens even if the case has not yet been formally accepted.

(1) Cases are electronically assigned, if eligible, to a particular CN. Upon receipt of the case, the CN should make a three-point contact in order to

effectively "triage" the case, and then report these findings via a COP Nurse Report to the SN and CE.

(a) Claimant – The CN should make initial contact with the claimant. Often this contact is the claimant's first experience with OWCP; therefore, it should be positive. It sets the tone for moving forward toward a positive outcome for the claimant. The CN should obtain details concerning the injury and determine whether the claimant has a treating physician. If so, contact information should be obtained. The CN can also answer general questions about OWCP.

(b) Employing Agency – The CN should contact the agency to confirm the claimant's work status and determine whether work accommodations are going to be available during recovery. The CN can also discuss with the EA whether he or she feels that a FN assignment would be beneficial in the particular case.

(c) Attending Physician – The CN should contact the physician's office to obtain information concerning treatment and the date of the claimant's next appointment. The CN can provide general information about dealing with OWCP, such as the address for submission of reports and how to submit authorization requests and medical bills should the claim be approved. The CN can also advise whether accommodations can be made at the EA.

(2) Once the information has been gathered, the CN enters it on the COP Nurse Report, along with other relevant information pertaining to possible issues or foreseeable barriers. The CN should also make a specific recommendation pertaining to whether a FN assignment would be beneficial.

(3) Once the COP Nurse Closure report is received, the SN reviews it and submits the bill for payment. At that point, the COP Nurse Report will be viewable by the CE, who can use the information provided to determine whether a referral for FN intervention is needed. The closure type and date will also be visible to the EA in the Agency Query System (AQS) at that time.

If the CN closes the case and the claimant has not returned to work in a full-time capacity, the case should be reviewed for adjudication action. See the Case Adjudication paragraph above for an explanation on the importance of expediting adjudicatory actions in these types of cases.

c. Field Nurse Assignments. FN services are a valuable tool for assisting claimants in returning to work and assisting CEs in moving a case towards resolution. Early referral for FN intervention services is critical to ensuring successful disability management, and FN assignment should occur as soon as possible after the injury occurs if the claimant has not returned to work. Referral for FN services may also be made if the claimant has returned to work but is disabled from performing his or her date of injury position.

(1) The need for a FN referral can be established with any of the following criteria:

- The claimant is disabled as a result of the accepted condition and has not returned to work. This is true even if a projected return-to-work date is on file but has not yet occurred. In this case, the FN will work with all parties involved to obtain a release to work or facilitate the return-to-work effort on the projected date.

- Surgery is authorized. In these cases, it is important to assign a FN prior to the actual surgery date if at all possible (unless the claimant is working full duty prior to the surgery) so that the FN can attend the pre-operative appointment with the claimant and assist with arranging any post-operative care that may be needed.

- Work tolerance limitations are on file but outstanding medical issues hinder or preclude a return to work. The FN can assist with the outstanding medical issue (e.g., physical therapy, medication, treatment plan, etc.).

- Work tolerance limitations are on file, but they are considered temporary pending further medical recovery. The FN can work with the claimant, EA and physician to obtain a return to work with temporary accommodations, stable and well-defined work restrictions, or a release to full duty.

- The anticipated return-to-work date does not coincide with the severity of the original injury, or the return-to-work date is extended without clear medical reasons. The FN can work with the claimant and physician to clarify the reason for the severity or delay and perhaps assist with obtaining authorization for medical treatment that would remove the barrier.

- The claimant is only working limited duty but may be able to return to full duty.

(2) The Nurse Referral. A FN can be assigned in an accepted case as soon as there is an indication that the claimant is out of work due to the work injury or disabled from performing the full duties of the date of injury position, as well as any of the reasons outlined in the prior paragraph. This referral can be made even if the claimant is still in the COP period following the injury and even if the OWCP has not yet made a wage-loss payment. A FN may also be assigned upon request by the EA for other reasons if the CE concurs that a FN would be helpful in resolving the case and the claimant is not already working full duty. How to make a nurse referral is discussed in more detail in PM Chapter 2-0811.

(3) Upon receipt of the referral, the FN is expected to meet with the claimant, attend medical appointments, monitor the claimant's return to work, visit the work site, and communicate with the CE, SN, AP and EA. The FN obtains and relays information through a combination of phone calls, written communication, and face-to-face interaction. The FN can assist in the following ways:

- Coordinate medical care if various medical providers are involved, e.g. an attending physician, a specialist, physical therapists, etc.

- Relay authorization information for diagnostic tests, equipment, surgery, etc.

- Obtain treatment plans from the attending physician and determine whether more active treatment or more active participation by the claimant in the recovery process may be needed. Also, the CE may want the FN to address any prolonged treatments such as physical therapy without clear goals or direction.

- Provide guidance to the CE where the claimant has sustained a catastrophic injury or has undergone surgery.

- Assist the CE in resolving medical issues.

- Assist in arranging for a Functional Capacity Evaluation (FCE) and/or work hardening program.

- Clarify work status and obtain work tolerance limitations, and then relay this information to the EA.

- Assist in work site evaluation following a return to work and monitor the claimant post return to work to ensure it is sustained.

- Address any problems the claimant may have in adjusting to the work setting.

- Obtain the date of maximum medical improvement.

- Recommend a second opinion examination.

- Recommend vocational rehabilitation services.

After receiving the referral, the FN should make the initial contacts with the EA, claimant and AP. The FN should then contact the CE to discuss the strategy for moving forward with the case. At that time, the CE can direct the FN to take specific actions as needed.

(4) CE and FN Interaction. During the period of FN intervention, the CE and the FN will confer, either by telephone or written communication, to determine the next action. Timely response to FN inquiries is crucial to successful case management. The CE determines the best approach to achieve progress in the case and directs the FN in obtaining necessary information or completing specific tasks needed to achieve those goals, as detailed in the prior section.

The FN may note such information as the physician's opinion concerning length of disability, work limitations, etc. The CE may use this information as the basis for questions to the physician but should not base adjudicatory actions on nurse reports.

The FN will report to the OWCP, either by telephone, in writing, or both. The FN's monthly report should outline accomplishments and action plans necessary to resolve barriers to sustainable return to work. Written reports are usually required every 30 days, but effective disability management hinges on more frequent communication in most cases.

(5) Length of Assignment. The length of a FN's involvement will depend on the specific circumstances in a case. An initial assignment period will be determined at the outset of the case, usually 120 days. This may be adjusted, however, depending upon the progress in that case. Return to work monitoring by the FN is automatic for 60 days after a light duty return to work, and for 30 days following a full duty return to work. These extensions are automatic, even if the extension takes the case beyond the initial 120-day assignment period.

If the CE determines that the FN could still be of assistance after that initial period, the CE should document the file extending the FN intervention for

30-60 additional days. A follow-up review should then be undertaken after that extension period has ended. As long as the CE documents the case file accordingly and the rationale for continued intervention is clear, the CE can extend the FN intervention period for up to 180 days. During this period, return-to-work 30/60 day extensions are automatic as well.

Rationale for extending the FN intervention period includes, but is not limited to, the following:

- Work tolerance limitations are expected shortly and the EA has indicated a willingness to accommodate the claimant.

- The claimant has undergone surgery during the initial intervention period, and the FN needs more time to work with the claimant and physician post-operatively to obtain a release to work.

- The claimant has returned to a temporary modified assignment, but the work restrictions are expected to lessen in the near future, and the FN could assist the EA with the formulation of a permanent position.

- A full-duty release is expected in the near future, and the FN would be able to assist with that transition back to full duty.

- The claimant has returned to a modified position, and the FN could monitor the claimant post return to work to ensure that it is sustained.

- A second opinion or referee examination was obtained during the initial intervention period which delayed the CE's determination of the work tolerance limitations that should be used for the return-to-work effort; therefore, the FN needs extra time to work with the EA on an appropriate job offer.

- The claimant has encountered medical setbacks or the recovery has been unusually delayed, and the FN's services would be beneficial to the claimant's medical recovery and/or return-to-work effort.

FN intervention past 180 days must be approved by a Supervisory Claims Examiner (SCE), upon recommendation of the CE, unless the extension is due to a 30/60 return-to-work monitoring period. Any extension beyond 180 days should also be discussed with the SN. Even with Supervisory approval, nurse intervention should usually be closed after 10 months of assignment, unless the case is catastrophic in nature.

The key for extending FN services in any circumstance is that the CE makes a purposeful decision for the extension with clear goals for the FN to accomplish during the next approved period. Extending the FN intervention period without clear direction and communication from the CE to the FN is not

permissible. The process for extending FN services is discussed in more detail in PM Chapter 2-0811.

(6) Dual Tracking. Based on the circumstances in the case, OWCP may determine that the assignment of a Vocational Rehabilitation Counselor (RC) simultaneously with FN intervention could be useful.

(a) Although not always necessary, dual assignment should be considered in the following kinds of circumstances:

- The claimant has a condition that will likely lead to permanent work related restrictions, which would prohibit a return to the date of injury position, and the EA has indicated that it will not have any work available for an individual within the expected restrictions. In this instance, the file should reflect expectations for when the restrictions will likely be permanent and the kinds of restrictions that are expected.

- If the EA needs vocational information and assistance with formulating a job offer, the RC and FN may work concurrently with the EA. In these instances, the RC may be able to provide vocational testing, transferable skills analysis, ergonomic assessments, and even arrange for short-term training that would enable the EA to make a job offer.

(b) If the CE determines that dual tracking would be useful, a rehabilitation referral will be sent to the RS for consideration. If the case is opened for both rehabilitation and nursing services simultaneously, the CE should send a letter to the claimant (with copies to the FN, RC, and EA) outlining the circumstances, roles of each party, and the claimant's expected cooperation with the return-to-work effort.

(c) If dual tracking occurs, the FN and RC have different roles, but each compliments the other. The FN should focus on the following:

- The claimant's medical condition in order to obtain permanent and/or stable, well-defined work tolerance limitations.

- Maintaining open communication with the physician while providing information as necessary to the CE and RC. Any needed communication by the RC with the physician should flow through or be coordinated with the FN (while still assigned to the case).

- Communicating with the SN, CE and RC as needed – documenting any communication in the monthly reports.

Once the FN obtains stable and well-defined work restrictions, FN intervention should be usually be closed, unless work with the EA is

necessary to complete a job offer, and the RC should commence with developing a return-to-work plan.

9. Vocational Rehabilitation Services. Returning the claimant to suitable work is the primary goal of vocational rehabilitation. It is a valuable resource for the return-to-work effort. In most cases, the earlier the claimant begins vocational rehabilitation, the greater the likelihood of a successful return to suitable, gainful employment.

Vocational Rehabilitation (VR) services are addressed in section 8104 of the FECA. Like medical treatment and wage-loss compensation, these services are a benefit to which the claimant may be entitled. While vocational rehabilitation is provided at the discretion of OWCP, participation on the part of the claimant is mandatory under the FECA.

The VR program serves a dual purpose: providing return-to-work services to the claimant while also providing a basis where appropriate for OWCP to make a determination on the claimant's capacity to earn wages. This paragraph will specifically address how vocational rehabilitation should be used in the disability management process to achieve a return to work. PM Chapter 2-0813 provides a comprehensive description of VR services.

The VR program is comprised of a Rehabilitation Specialist (RS), who is located in the district office, and the RC, who works on a contractual basis in the district office's servicing area. The CE, with recommendations from the RS, is responsible for the management and overall direction of the case, even during the VR period.

a. Vocational Rehabilitation Roles.

(1) The RS plays an important role in the VR process. The RS's responsibilities include, but are not limited to, the following:

- Ensuring there is a sufficient number of counselors to service the district office's needs.
- Monitoring the RC's performance in correlation to both the contract specifications and the quality of service provided.
- Assigning RCs to particular cases.
- Reviewing RC reports for completeness and timeliness prior to authorizing payment of bills.
- Communicating with the CEs regarding the cases assigned for VR services.
- Relaying important or time-sensitive information to the CEs so that action can be taken if needed, e.g. a new issue with the claimant's medical condition that is hampering the VR effort.
- Providing training and guidance to CEs in regard to how to recognize

when vocational services are necessary to assist the claimant with returning to work, and serving as a vocational resource to the CEs.

- Providing solutions for return-to-work barriers in cases.

(2) The RC is a certified counselor who assists with the VR effort in a number of ways. The RC's contact is usually in person with the claimant since

he or she is assigned by area when available. The RC's responsibilities include, but are not limited to the following:

- Evaluating the claimant's vocational abilities and transferrable skills.
- Arranging for vocational testing and training.
- Overseeing Occupational Rehabilitation Plans.
- Conducting labor market surveys.
- Formulating a vocational re-employment plan.
- Assisting the claimant with job-seeking skills such as resume building and interview techniques.
- Arranging for specialized ergonomic job and home modification services.
- Making recommendations to the RS and CE if a particular barrier is hindering the return-to-work effort.
- Working with the FN during a dual tracking period.

b. Referral for rehabilitation services should be made in the following circumstances:

(1) If the claimant has been released to work and the FN intervention period has ended, the claimant should be able to work at least four hours per day if the goal is return to work with the date of injury employer. If return-to-work services with the EA have been exhausted and the goal of rehabilitation is placement with a new employer, the claimant should be able to work on a full-time basis and should be capable of at least sedentary work. A referral for a work release of only 4 hours can be considered in some circumstances, and the CE and the RS should discuss this option, especially if part-time work may be available.

(2) If the physician recommends work hardening and work restrictions are

expected after completion of the program, the claimant can be referred to vocational rehabilitation for an Occupational Rehabilitation Program (ORP). Once restrictions are established, the rehabilitation services will then focus on return-to-work efforts.

(3) A Dual Tracking period with FN services and VR services may be helpful, as outlined in the prior paragraph, 8(c)(6).

c. Return to work with the EA (not involving Dual Tracking) is only to be undertaken by the RC if the CE and FN nurse have not previously exhausted all attempts to get a suitable job offer.

(1) The time frame for placement with the previous employer is a maximum of 90 days, although if the EA chooses not to make an offer early during this phase, the phase should be much shorter.

(2) During this phase, the claimant, RC, EA and CE all participate in the return-to-work effort. A conference call is often helpful to address any issues that arise which may impede this process. Conferences are discussed later in this chapter.

(3) If the outcome of this phase is positive and the claimant returns to suitable employment with the agency, the RC should remain on the case for 60 days after the return to work. At that time, OWCP should be in a position to issue a formal loss of wage-earning capacity decision, if applicable. If the claimant is working full time in a light duty position, but the position is not one for which a formal loss of wage-earning capacity decision can be issued, the RC should ascertain whether that position will continue indefinitely or whether further VR services would be helpful in formulating a permanent job offer. If further services will not be helpful, VR will close at that time.

(4) If the claimant does not return to work during this phase, there are two possible outcomes. If the claimant refused to accept a suitable offer of employment, the CE should follow sanction procedures under Section 8106 of the FECA, as discussed in FECA PM Chapter 2-0814. If the agency failed to offer employment, the VR effort should move on to the next phase, the development of a plan for placement with a new employer.

d. Plan development is the next phase of vocational rehabilitation. During this phase, the RC should gather information about the claimant's work history, education, and transferable skills. This information is then compared to the jobs available in the local labor market where the claimant resides.

(1) If the claimant has sufficient transferable skills to obtain employment that is reasonably available in the local labor market, a placement plan is put

into place. The claimant will be provided with placement assistance (resume and interviewing skills, job leads, etc.) for 90 days. If the claimant secures a job, the counselor will follow up for 60 days to ensure a successful return to work. If the claimant does not obtain a job or fails to take advantage of the placement assistance provided, a constructed loss of wage-earning capacity decision can be considered based on the job(s) identified in the placement plan.

(2) If the employing agency cannot offer a job and the claimant is unemployable in the local labor market with his or her current skills, a training plan can be pursued if vocational testing establishes that the claimant has the necessary aptitude. The claimant can be provided training to prepare him or her for a job that is reasonably available in the local labor market. Once the training period has ended, the claimant is offered placement services as described above. If training is needed, short-term or pre-vocational training that would serve to upgrade basic skills are the preferred options. Long-term training plans should be pursued as a last resort, since returning the claimant to work in the shortest time possible is a primary focus of vocational rehabilitation.

e. Dual Tracking. OWCP may determine that the assignment of a RC simultaneously with FN intervention in certain circumstances could be useful, as noted earlier in this chapter. The referral for the RC in these cases will be for Medical Rehabilitation, and the period will usually be limited to 3 months for concurrent services.

If the EA needs vocational information and assistance with formulating a job offer, the RC and FN may work concurrently with the EA. In these instances, the RC may be able to provide vocational testing, transferable skills analysis, ergonomic assessments, and even arrange for short-term training that would enable the EA to make a job offer.

In other cases, where the EA has determined there will be no job opportunities for the claimant, the claimant's work restrictions may not yet be stable and well defined. As a result, full plan development cannot begin immediately with these claimants, but, in the interest of expediting the return to work, the RC may assist with work hardening and functional capacity evaluation scheduling and begin the groundwork for the development of a return-to-work plan by obtaining the claimant's work history, performing preliminary labor market surveys, and conducting transferrable skills analysis.

The FN should focus on the medical aspects of the case, and the RC should focus on the vocational aspects of the case. Once the claimant has stable and well-defined restrictions, nurse intervention should usually cease (unless continuing assistance to the EA would be helpful in formulating a job offer), and the RS will direct the RC to begin actual plan development.

10. Employing Agency Intervention. The EA has a vested interest in returning the claimant to work as soon as possible, so partnering with the EA throughout the return-to-work process is important to a successful outcome.

The first step in the disability management process is solely within the EA's purview – the transmission of new injury claims and subsequent wage-loss claims. The quicker the EA transmits the new injury claim and supporting evidence to the OWCP, the sooner the OWCP can take action on the claim. If the case can be accepted upon initial review, the CE can move straight into disability management if the claimant is losing time from work or disabled from performing his or her date of injury position.

It is also the EA who first speaks to the claimant about the OWCP and what to expect after a claim is filed. For that reason, the OWCP should partner with the EA throughout the process so that the EA can effectively communicate the purpose of the FECA program to the claimant and convey from the outset that medical recovery and return to work are the ultimate goals.

a. Communication between the OWCP and the EA. Since the EA and the OWCP have the same goal of the claimant returning to work as quickly as possible, it is important to maintain open and ongoing communication with the EA throughout all stages of disability management.

During the disability management process, the OWCP should be able to expect the EA to:

Notify the OWCP promptly when the claimant either returns to work or does not return to work after being released by the AP and notified of the availability of modified work.

Allow the FN and/or RC access to the claimant's work site.

Maintain contact with the claimant and address the claimant's concerns about personnel issues such as retirement and health insurance benefits that may be affected by a return to work.

Communicate any medical updates to the OWCP.

The EA should expect the following from the OWCP during the disability management process:

Information relevant to the return-to-work effort, especially work tolerance limitations.

Pertinent information obtained by the FN and RC that would enable the EA to formulate a job offer.

Prompt determinations on medical issues and the suitability of job offers

when needed.

Communication as described above will occur both telephonically and via written correspondence, but use of the phone (with documented CA-110s for the file) for many issues is the best way to resolve outstanding issues.

b. Job Offers. The most important action of the EA can be the formulation of a job offer within the claimant's work restrictions. The CE can solicit a job offer once work restrictions are obtained. The EA may also obtain the work restrictions through the FN, physician, or even the claimant. Once obtained, it is up to the EA to provide work accommodations and create a suitable job.

The EA will determine whether work accommodations can be made when medical restrictions are presented. The FN can assist with this process during nurse intervention, and the RC can assist with this process during vocational rehabilitation. If work accommodations are available for a partially disabled claimant, the EA will advise the claimant in writing of the specific duties and physical demands of the modified position. Offers of employment are addressed in detail in PM Chapter 2-0814.

If a FN is assigned to the case, but the EA, the FN, or the OWCP believes that vocational rehabilitation services may also be beneficial for the return-to-work effort (perhaps to arrange for specific job training or address ergonomic issues unable to be addressed by the FN), then a RC can be assigned concurrently to assist with the return-to-work effort.

11. Claimant Intervention. The most important party in the return-to-work process is the claimant. All interventions and CE actions are done with one goal in mind, ensuring that the claimant recovers and is able to return to work in a sustained capacity following a work injury. Claimants must therefore understand from the very beginning that the OWCP is in fact a return-to-work program – not a retirement program. The EA plays a large part in encouraging return to work, but it is the OWCP's responsibility as well to convey the advantages of a speedy return to the workplace.

a. Retention Rights. A primary goal of disability management is to return the claimant to work as soon as possible, but particularly within one year of the onset of disability. This one-year deadline is significant because section 8151(b) of the FECA requires the EA to offer the claimant his or her former position or its equivalent if the injury or disability has been overcome within one year. If the disability is overcome after one year, the EA must make "all reasonable efforts" to rehire the claimant. In practice, this means that in some cases there may be only a one-year window of opportunity for return to work with the EA. It is therefore essential that a return-to-work agenda be emphasized early in the life of an accepted disability claim to take advantage of this limited opportunity so that the claimant does not lose his or her opportunity to continue in the Federal employment system and does not sustain a negative impact on retirement benefits.

If the claimant has not returned to work and that one-year time frame is approaching, the claimant should be reminded of his or her retention rights. Approximately two months prior to the one year mark, or at the end of efforts to place the claimant in a job with the previous employer (whichever occurs sooner), the claimant should be advised in writing that the previous employer has not identified a job meeting the claimant's work limitations and that contacts with the previous employer do not indicate that any such offer will be forthcoming. It is also appropriate to alert the claimant at this time that the OWCP will begin vocational rehabilitation plan development if the claimant can work in some capacity, and that the rehabilitation effort will prepare the claimant for other work, possibly with another government agency but probably with a private employer. The CE uses the "Ten Month" letter for this purpose.

b. Communication between the OWCP and the Claimant. Early in the disability management process, the FN plays a key role in communicating on behalf of the OWCP. The CE may also need to communicate with the claimant as well to clarify any questions the claimant may have. Timely responses to the claimant's inquiries will foster a good relationship with the claimant and alleviate any concerns he or she might have about the status of his or her case moving forward. As outlined earlier in this chapter, timely customer service and prompt payment of compensation claims build trust with the claimant and enable the claimant to concentrate on recovery and return to work.

Beyond routine customer service items, the CE or other designated staff will also communicate with the claimant when:

- A FN and/or RC are assigned to the case.
- Medical information is requested from the AP.
- The claimant is scheduled to report for a second opinion or referee examination.
- A job has been determined to be suitable and the claimant is expected to return to work.
- The various stages of vocational rehabilitation begin.

12. Conferences. As noted throughout this chapter, ongoing and steady communication between all parties involved in the disability management process is vital to a successful resolution. Conferences are a particularly effective means of addressing any issues that arise that may impede the return-to-work process. Conferences are also helpful when miscommunication between one or more parties has occurred.

There are two types of conferences – formal conferences and informal conferences. Formal conferences are discussed in PM Chapter 2-0500. Formal conferences require a memorandum of conference, as well as a follow-up comment period. When due process is involved, e.g. during the adjudication of a claim or reaching a final determination in an overpayment case, a formal conference is needed. At other times, though, an informal conference may be sufficient.

a. An informal conference during disability management is a form of mediation, and the goal is to address the concerns of all involved parties and arrive at a solution that is agreeable to everyone. Some reasons for conferencing during the return-to-work effort include, but are not limited to, the following:

(1) Medical evidence used for a return to work may be disputed by the claimant or the EA. An explanation of how medical evidence is afforded the weight for return-to-work purposes can alleviate these concerns.

(2) The duties of a limited duty position offered by the EA may not be described sufficiently so that a determination on suitability can be made. Additionally, a claimant may have a different idea about the requirements of a described job duty than the employer. Discussing these concerns and arriving at an understanding of the actual duties of an offered position can serve to inform the EA of how the job offer should be written and to alleviate the claimant's concerns that a particular job requirement exceeds his or her work abilities.

(3) Wage disparity can be a major deterrent to a claimant seeking to return to work. During the conference, the CE can explain the loss of wage earning capacity procedures and assure the claimant that income will not decrease even if the wages of the limited duty position are lower than those of the date of injury position.

4) Personnel issues may not affect the suitability of a job offer as reviewed by the OWCP, but they can present obstacles to a successful return to work. For example, the claimant may object to a new work schedule. The conference allows an opportunity for all parties to express concerns and for a compromise to be reached whenever possible.

(5) Placement with a new employer may not be the claimant's desire. He or she may want to retain Federal status instead. If the EA is unable to make a job offer, the placement period during vocational rehabilitation is critical to a successful outcome for the claimant. If the claimant is aware from the beginning what will happen at the end of the placement period, e.g. a likely reduction of

benefits with or without placement, he or she is more likely to cooperate fully during the placement period.

b. Participants in the Conference. A conference is usually held with the CE plus two or more parties. During nurse intervention, the FN will often be involved as well as the EA and the claimant. During vocational rehabilitation, often times the RS and the RC will participate along with the claimant and CE. There are no set rules on who should be part of the conference or how many people should participate. Whichever parties can help resolve the issue at hand should be involved.

c. Elements of an Informal Conference. Unlike a formal conference where an actual conference memorandum is necessary and the memorandum is mailed to the participants, informal conferences can usually be documented with a complete and thorough CA-110 or memo in the case file. Regardless of the format used, the conference should be fully documented in the file. Whether using a CA-110 or memo, it should contain the following information:

(1) A heading at the top annotating the call as a Conference.

(2) A list of who was involved in the conference and his or her role in the process, e.g. Jane Smith – EA Injury Compensation Specialist.

(3) Descriptive but thorough bullet points may be used in lieu of a full narrative, but the CE should be careful to attribute specific comments to specific individuals.

(4) If any action was promised as a result of the conference, the bottom portion of the CA-110 should clearly outline the pending actions.

(5) While a narrative memorandum is not needed, the CE must still ensure that the CA-110 or memo contains an accurate depiction of the content of the conference.

d. Follow Up Actions. Because these conferences are used to address various return-to-work issues and resolve any miscommunication, as opposed to formal adjudication actions, a formal follow up is not required. Often times the conference itself will have resolved the issue at hand. Other times, the CE's follow-up actions (letters, second opinion referrals, requests for a new job offer, etc.) will reflect information discussed during the conference.

13. Intervention Strategies and Timing. Each interaction between the CE and the claimant, EA or AP should be used to ensure the claimant's recovery is progressing and to emphasize the goal of return to work. Brief but timely inquiries and open communication with all involved parties are effective tools in conveying case management goals and encouraging a successful return to work. Interventions may involve any of the types described in this chapter, and, as previously noted, these intervention actions can and should overlap for effective disability management. Taking actions sequentially is not usually the most effective method. Intervention actions are most effective when used simultaneously.

a. Key Strategies for Disability Management.

(1) Consider the evidence in the specific case file. The appropriate intervention to take on a specific case is based on a number of factors, including the accepted condition, extent of injury, treatment provided, availability of work accommodations, and other variables.

(2) Identify any pending obstacles or barriers to medical recovery and return to work.

(3) Anticipate the outcome of the possible intervention actions. Prior to taking an action, the CE should anticipate the possible outcome of such an action to determine whether the action will enable the disability management effort to progress.

(4) Decide on the best intervention action to resolve any pending issues in the case and then move forward.

(5) Assess the outcome of the intervention action taken. Did the intervention action yield the necessary outcome to move forward in the case?

(6) React to the new evidence in the file and repeat the five steps outlined above again until the case has been resolved.

b. Choosing an initial Disability Management strategy. Decisions made early in the disability management process are crucial to minimizing the effects of a work related injury in the long-term. The CE should review the specific circumstances of the case and utilize judgment in deciding which strategies to employ in order to minimize disability and the effects of the work injury. Initial actions will not be the same for every case. For instance, if the claimant is off work because of a pending surgery, this would require different intervention than a case where the claimant has undergone treatment and the physician anticipates a return to work in the very near future.

Choices made upon initial review of the claim can affect the return-to-work effort. For example, if a claimant files a claim for carpal tunnel syndrome and submits a medical slip stating "off work pending carpal tunnel release," the CE knows even

before the case is adjudicated that the claimant is out of work. The CE therefore needs to make a decision about the best way to obtain the evidence necessary to adjudicate the claim so that disability management actions can be initiated and compensation can be paid if the case is ultimately accepted. Tailoring the development letter to request information about the possibility of surgery, while

simultaneously requesting the evidence needed to adjudicate the case, is one way to begin the disability management process before the case is even accepted.

c. Adjusting Disability Management strategies as the case progresses. As the claim progresses through the disability management process, the CE should regularly assess the claimant's medical condition and return-to-work status and decide what type of intervention is appropriate. Tailoring the kind of interventions taken to the specific circumstances of the case and anticipating the outcome of each intervention is key to successful disability management. For instance, a conference call might be appropriate to address a claimant who is not fully cooperating with the vocational rehabilitation process, but it will not be useful in a case where disability has recurred and medical management is needed. A few examples of the decision making process are outlined below.

(1) If the claimant has not returned to work, the CE should usually write directly to the AP first or seek the assistance of the FN in addressing necessary issues with the AP. However, a second opinion should be scheduled if the AP fails to submit rationalized medical evidence that clearly establishes the claimant's work tolerance limitations. Alternatively, there may be a benefit to taking both actions at the same time. If the AP does not respond to the letter or provides an inadequate response, a second opinion will already be in process to obtain the requested information. If the AP does respond, the opinions of the two physicians can be compared and weighed to determine the next disability management action. Should a conflict of medical opinion exist, a referee examination can be scheduled to clarify and resolve the issue.

(2) If the EA fails to make a suitable job offer, the CE should direct the FN to work with the EA on the formulation of such an offer. If the EA cannot or will not make a job offer, a conference should be considered. If a job offer is still not forthcoming, the case should be referred for vocational rehabilitation.

(3) If the claimant has been released to work, but a FN is no longer assigned to the case, the CE can request a job offer from the EA and refer the case for VR. Taking these actions simultaneously is usually the best strategy so that a RC can assist with the creation of a job and provide adjustment counseling to the claimant, which should result in a smoother transition back into the work environment for the claimant.

(4) If the claimant develops a disabling medical condition after VR efforts have been initiated, the CE should assess the medical evidence to determine whether the condition is work related. After contemplating the outcome of

the various options, the CE needs to decide whether to approach the AP, refer the claimant for a second opinion, or pursue both courses of action simultaneously. During this medical intervention, the CE and RC should continue to communicate with the claimant so that return to work remains the ultimate goal even during this period of development.

d. Intervention Timing. Though intervention actions vary, timely and appropriate interventions do help to minimize the length of disability by maintaining focus on the goal of assisting claimants in returning to work.

As stated previously, a primary goal of disability management is to return the claimant to work as soon as possible, but particularly within one year of the onset of disability. It is critical that the CE be attentive to the specific issues of each case in order to actively manage the case and take timely action on any situation to achieve this goal. CEs should use all available tools, including reminders and reports, in order to take substantive actions on disability management in a timely fashion. While in active disability management, the case should usually be reviewed often and as frequently as necessary to ensure intervention actions and the disability management strategy are on course. This consistent focus will allow CEs to address issues hindering recovery, facilitate return-to-work efforts, and move cases towards resolution.

14. Resolution of Disability Management Cases. The CE should actively manage the case until the claimant reaches maximum medical improvement and a resolution is reached regarding the claimant's work capacity. There are several possible outcomes; the purpose of this paragraph is to describe these possible outcomes.

Following are the most likely outcomes, along with any associated decision and the steps needed to pursue that course of action.

a. Complete recovery from injury-related conditions.

(1) In cases where the claimant has completely recovered from the employment injury and returns to the job he or she held when injured, no formal decision is necessary and the case may be closed if the claimant has been released from care.

(2) In some instances, the claimant has fully recovered but does not return to the date of injury position. The claimant has no ongoing entitlement to compensation for wage loss and medical benefits once the injury-related condition has resolved. In these cases, a formal decision following a notice of proposed termination is necessary to notify the claimant of this change in entitlement. (Formal decisions are discussed in PM Chapter 2-1400.) As the claimant's response may change the preliminary determination to terminate compensation, the OWCP should continue any nurse and/or rehabilitation services during the notice period until a formal decision with appeal rights is issued, unless the claimant is already in receipt of OPM benefits.

b. Complete recovery from injury-related disability.

(1) In cases where the claimant has recovered from the employment-related disability and returns to the job he or she held when injured, no formal decision is necessary. If the claimant has returned to the date of injury position but still requires ongoing medical treatment, the case can be left open for medical benefits.

(2) In some instances, the claimant recovers from the injury to the point that he or she is capable of performing the date of injury position but does not actually return to that job. The claimant has no ongoing entitlement to compensation for wage loss once the medical evidence establishes the claimant's ability to perform the date of injury position. In these cases, a formal decision following a notice of proposed termination is necessary to notify the claimant of this change in entitlement. (Formal decisions are discussed in PM Chapter 2-1400.) As the claimant's response might change the preliminary determination to terminate compensation, the OWCP should continue any nurse and/or rehabilitation services during the notice period until a formal decision with appeal rights is issued, unless the claimant is already in receipt of OPM benefits.

c. Return to modified work, with or without wage loss.

(1) Re-employment with no Loss of Wage Earning Capacity (LWEC).

(a) If the claimant returns to a new position or a modified version of the date of injury position with the previous employer at a pay rate commensurate with the current pay for the job held when injured, the claimant has no loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days, the CE should review the case to determine whether the medical evidence establishes permanent restrictions and whether the position fairly and reasonably represents the claimant's wage earning capacity. If so, the CE should prepare a formal decision making this finding. This type of decision is necessary even though there technically is no loss of wage earning capacity. See PM Chapter 2-0814. If the position does not fairly and reasonably represent the claimant's wage earning capacity, no decision can be issued. Different resolution codes are used for each of these scenarios.

(b) If the claimant returns to work with a new employer at pay rate commensurate with the current pay for the job held when injured, the claimant has no loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days and the medical evidence establishes permanent restrictions, the CE should prepare a formal decision addressing whether the earnings fairly and reasonably represent the claimant's wage earning capacity.

(2) Re-employment with LWEC.

(a) If the claimant returns to a new position or a modified version of the date of injury position with the previous employer and is earning less than the current pay rate of the job held when injured, the claimant has sustained a loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days, the CE should review the case to determine whether the medical evidence establishes permanent restrictions and whether the position fairly and reasonably represents the claimant's wage earning capacity. If so, the CE should prepare a formal decision making this finding. See PM Chapter 2-0814. If the position does not fairly and reasonably represent the claimant's wage earning capacity, no decision can be issued.

(b) If the claimant returns to work with a new employer and is earning less than the current pay rate of the job held when injured, the claimant has sustained a loss in wage earning capacity as a result of the injury. Once the claimant has satisfactorily performed the position for a period of at least 60 days and the medical evidence

establishes permanent restrictions, the CE should prepare a formal decision addressing whether the earnings fairly and reasonably represent the claimant's wage earning capacity.

d. Determination of LWEC without actual job placement. This type of decision can be issued after the OWCP has made reasonable efforts to return the claimant to work and has advised the claimant of his or her rights and responsibilities. See PM Chapters 2-0813, 2-0814, and 2-1400.

In these cases, the claimant has been notified that the OWCP will provide vocational rehabilitation assistance leading to re-employment. The claimant is able to return to work and the file contains documentation that establishes appropriate work is reasonably available in the local labor market; therefore, benefits are adjusted to reflect any loss in wage earning capacity. The OWCP issues a decision based on the selected jobs, regardless of actual employment status.

In this instance, the CE will prepare a pre-reduction notice, addressing the claimant's loss of wage earning capacity based on a suitable position for which the claimant received training and/or placement efforts. After the notice period ends, a formal decision establishing the claimant's wage earning capacity will be issued, taking into account any evidence or arguments submitted during the notice period.

e. Application of sanctions. A claimant's failure to cooperate with the OWCP's rehabilitation and/or reemployment efforts may result in the suspension, reduction, or termination of benefits.

In these cases, the claimant has been notified of the obligation to participate in vocational rehabilitation efforts and has been provided vocational rehabilitation assistance leading to re-employment, either in the private sector or with another Federal agency. If the claimant continues not to cooperate, even after being warned of the consequences of non-cooperation, the CE will proceed with the reduction or suspension of benefits. Alternatively, a formal decision may be issued for failure to accept suitable employment. See PM Chapters 2-0813, 2-0814, and 2-1400.

f. A finding that the claimant has no wage earning capacity or re-employment potential for the indefinite future can be made on the basis of a medical or vocational determination. If no rehabilitation plan can be developed due to the severity of the claimant's medical condition and/or the limited job market in the claimant's commuting area, the CE may determine that the claimant has no wage earning capacity. If there is no expectation of further recovery or a change in the vocational determination or medical condition, the case can be placed in PN status with the concurrence of the Supervisory Claims Examiner. See PM Chapter 2-0812. This determination, however, should not be made during the early period of disability, especially during the first 30 months, except in rare circumstances.

2-0601 Disability Management Tracking

TABLE OF CONTENTS

1. Purpose and Scope. This chapter describes the Disability Management (DM) Tracking System in the Integrated Federal Employees' Compensation System (iFECS), through which periods of disability and intervention actions associated with Case Management, Nurse Intervention and Vocational Rehabilitation are monitored. It addresses why and how a disability management record is created, managed, updated and resolved. It also addresses coding and data entry for this system and describes the relationship between the DM Tracking System and the tracking system for nurse and vocational rehabilitation activity.

Information related to the various DM components can be found in other chapters of the Federal Employees' Compensation Act (FECA) Procedure Manual (PM).

a. The DM process is outlined fully in FECA PM 2-0600, Disability Management.

b. Medical management is discussed in FECA PM 2-0810, Developing and Evaluating Medical Evidence. See also Part 3 Medical.

c. The Nurse Program is outlined in FECA PM 2-0811, Nurse Case Management, and FECA PM 3-0201, Staff Nurse Services.

d. Monitoring disability claims paid on the periodic roll is discussed in FECA PM 2-0812, Periodic Review of Disability Claims.

e. The Vocational Rehabilitation Program is outlined in FECA PM 2-0813, Vocational Rehabilitation Services, and in the Office of Workers' Compensation Programs (OWCP) PM Part 3, Rehabilitation.

2. Introduction. OWCP is responsible for assisting injured workers with medical recovery from a work injury and facilitating a return to work as soon as practicable so that the length of disability is minimized. The processes relating to these functions are collectively known as Disability Management (see FECA PM 2-0600).

Disability Management is comprised of both the Quality Case Management (QCM) phase of a disability case, which encompasses the first 30 months of disability, as well as the Periodic Roll Management (PRM) phase, when disability continues beyond the initial 30 months. The DM Tracking System is used during both the QCM and PRM phase of a case.

The DM Tracking application is used to track the actions taken during the DM process, as well as critical return-to-work and case closure data used by the Division of Federal Employees' Compensation (DFEC). This system measures the duration of disability, the effectiveness of case management actions, the success of returning injured workers to employment, and case resolutions following disability which resulted from a work injury or illness.

Consistent and accurate coding in the DM Tracking System is essential for proper analysis and measurement of actions taken during the DM process.

3. DM Goals. To measure performance, OWCP tracks disability cases and focuses on two overarching goals, return-to-work and case resolution. These goals are tracked and measured in several different ways, with much of the data taken directly from DM Tracking. The various specific goals provide a measurement of the effectiveness of case management.

a. Return to Work. Returning the claimant to work as soon as possible, but especially within one year of the onset of disability, is the primary goal of disability management. This one-year deadline 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 fully overcome within one year. See PM Chapter 2-0600-11(a), which discusses retention rights in greater detail. This one-year time frame is utilized in the tracking of lost production days.

(1) QCM Lost Production Days (LPD). QCM LPDs begin to count on the date disability begins and continue to count either until the employee has returned to full-time work or until certain closure codes are entered into DM Tracking.

(a) The formula used to compute the average LPDs assumes that each employee will remain off work for the entire first year; therefore, for each employee who has not returned to work during year one, the total number of lost production days defaults to 365. When the employee returns to work, the number of LPDs for that employee is adjusted to reflect the actual number of days of disability.

(b) LPDs are calculated differently in cases where the return to work is less than full-time. If a claimant returns to part-time employment, the LPDs continue to count, but each day defaults to a partial day, as opposed to a full day.

(c) When a claimant returns to work, or some other action is taken to resolve a case within the first year of disability, the overall LPD average should drop. The sooner the return to work or case resolution, the greater the reduction in average LPDs.

(2) Return to Work within Two Years. On July 19, 2010, the President established a 4-year Protecting Our Workers and Ensuring Reemployment (POWER) Initiative, covering fiscal years 2011 through 2014. The POWER Initiative extends prior workplace safety and health efforts of the Federal Government by setting more aggressive performance targets, encouraging the collection and analysis of data on the causes and consequences of frequent or severe injury and illness, and prioritizing safety and health management programs that have proven effective in the past.

(a) One of the seven goals in the POWER initiative is speeding employees' return to work in cases of serious injury or illness. The DFEC measures this goal by tracking return to work rates within a 2-year period.

(b) Not all DM cases count toward this 2-year goal, but all cases measured for this goal are taken from the existing DM universe. Note that only the 14 government agencies with the largest, statistically-significant case volumes (excluding the United States Postal Service) are included in this POWER goal.

(c) Since goal 7 of the POWER Initiative focuses on return to work with the original employer (at the Department level), a success is achieved only when the injured worker returns to work with the

original employer within the two-year tracking period (which starts when the OWCP creates the DM record).

b. Resolutions. The term resolution has slightly different meanings depending on the phase of the case – QCM or PRM. Paragraph 13 of this chapter discusses the various types of resolutions in more detail.

(1) QCM Resolution. The QCM resolution goal is a measurement set at 30 months from the date disability begins. Regardless of whether or not the claimant returns to work, a case will remain in the QCM universe until a resolution is reached, or the case reaches 30 months from the date disability began. In general, a QCM resolution means that a final decision has been reached on a case if the claimant has not returned to his or her date of injury job. Resolution examples include a termination for no continuing disability, a formal loss of wage-earning capacity (LWEC) decision, etc.

If the claimant remains totally disabled and/or no resolution code has been entered into the DM Tracking System by the 30-month mark, the case will be considered unsuccessful with regard to DFEC's QCM resolution goal. At that time, the case moves into the PRM universe if there is continued wage loss.

(2) PRM Resolution. Unlike the QCM resolution goal, there is no specific timeframe for achieving a PRM resolution in a specific case. A case will remain in the PRM universe indefinitely until a resolution is reached. The types of resolutions discussed above, however, for QCM also count as resolutions in PRM cases, e.g. a return to full duty work, return to light duty work with a formal LWEC decision, a termination for no continuing disability, etc. There is one addition, though, for PRM cases that does not apply to QCM. Because of the nature of PRM cases (longer term disability), a determination that there has been no change in the claimant's entitlement may also count as a resolution as long as the medical and factual evidence in the file reflect this finding; the case, however, remains in the PRM universe.

4. DM Records. A DM record should be created for each period of disability. Some cases may have more than one period of disability and, therefore, multiple records may exist throughout the life of a case, but only one DM record should be active in a particular case at one time.

In some instances, a record will be automatically created, and in other instances a record must be manually created. It is important that the Claims Examiner (CE) recognize the need to create a DM record manually so that periods of disability can be appropriately tracked and managed.

a. When to create a DM record. Tracking and management of a DM case begins early in the life of a case. Early tracking aids the CE in managing the case by providing the CE with a mechanism to record case management actions and return to work (RTW) data until a resolution is reached.

(1) Case Acceptance. A DM record should be created as soon as a case is accepted and the evidence indicates that the claimant has not returned to work as a result of the injury. A DM record can also be created at the time of acceptance if the claimant is working but is still disabled from his or her date of injury position.

(2) COP Nurse Closure. In traumatic injury cases where a COP nurse has been assigned, a COP Nurse Closure report is on file, and there is no evidence in the file reflecting a full-time RTW date, the CE should review the case for appropriate DM actions. If the claimant has not returned to work, and there is no clear imminent RTW date, a DM record should be created in an accepted case, even if the COP period has not yet expired. A DM record can also be created at the time of COP Nurse case closure and case acceptance if the claimant is working but is still disabled from his or her date of injury position.

(3) Lost Time from Work. A DM record should be created any time after acceptance of the case when the claimant is disabled from work due to the work-related condition(s).

(a) When the CE first becomes aware that the claimant is disabled from work (even if the COP period has not expired or a wage-loss claim has not yet been received).

(b) The first CA-7, Claim for Compensation, is approved for a non-intermittent period of leave without pay, and medical evidence supports continued disability from work.

(c) A recurrence of disability is accepted.

(d) If surgery is approved, the CE can ascertain the date of surgery (which would equate to disability from work). The DM record can then be created at the time of surgery, even if a CA-7 has not yet been received.

b. DM Start Dates and Track Dates. When a DM record is created, these two dates are of particular importance. The goals outlined in the preceding section track from one of these two dates; therefore, it is of the utmost importance that they be accurate.

(1) The Start Date is the date that the DM record was created. This date cannot be modified.

(2) The Track Date usually reflects the date wage loss or the period of disability began. The Track Date can be entered by the CE when a DM record is manually created. This date can be modified by those who are authorized to do so, generally at a level higher than a CE.

(a) If the claimant returns to full-time light duty work before the DM record is created, the Track Date is the same as the Start Date. LPD will not be measured in these cases, but DM performance with regard to resolution tracking will be based on the Track Date.

(b) If the claimant returns to part-time light duty work before the DM record is created, the Track Date should be the date of the part-time RTW and partial LPDs will be counted. See paragraph 2-601-3a(1) for more discussion on how LPDs are calculated.

(c) For total disability cases, LPDs begin with the Track Date and are counted as explained in paragraph 2-0601-3a(1).

c. Maintaining the DM Record. Once the record is created, DM Tracking allows the CE to enter information regarding disability, intervention actions, work status, and medical work restrictions. The CE is responsible for maintaining the DM record so that it accurately reflects the intervention actions taken to assist the claimant in recovery and return to work.

Each DM code and date should correspond to an intervention action or change in case status. These codes should be entered promptly when actions are taken so that the DM record reflects a history of the actions taken as the case progresses towards resolution.

Intervention codes -- including intervention actions, optional process codes, and closure codes -- should be entered on the Disability Tracking tab in the DM record in iFECS. Information about work status, job offers and suitability, and corresponding dates is entered on the Work Status Tracking tab in the DM record. When RTW information is saved, the data populates the first screen and LPDs are automatically updated, if applicable. Information about work restrictions can be entered on the third screen of the DM record to assist the CE in effectively documenting the record.

Some codes are mandatory and some codes are optional. The remaining paragraphs in this chapter discuss the coding structure in detail.

5. DM Categories. When DM codes are entered, they automatically trigger updates to the DM categories. These categories reflect the progress of a DM record from the beginning stages until resolution is reached.

If a return to work without wage loss or other resolution is not achieved during the initial 30 months of QCM disability tracking, the DM record continues to be tracked and managed in the PRM universe until a resolution can be reached. If the resolution of a QCM case involving ongoing partial disability does not trigger a closed DM record, the ongoing disability is also managed and tracked under PRM.

The DM category codes and descriptions are as follows:

QCM – Triage	A DM record is open and a COP Nurse has been assigned.
QCM – Resolved Triage	The claimant has returned to work full time within the 45-day COP period.
QCM - Open	A DM record is open and does not have a return to work date. A QCM-Triage category may be of record prior to this category, but not always.
QCM – Working Light Duty	The claimant has returned to work at less than full duty, but a loss of wage-earning capacity (LWEC) decision has not been issued.
QCM – Complete	The claimant has returned to work at full duty, or at modified duty with no loss of wage-earning capacity, a formal decision has been issued regarding the claimant's future entitlement (e.g. no injury-related disability, refusal of suitable work), or some other resolution code has been entered indicting no

	further entitlement to compensation (e.g. the claimant has elected retirement benefits). No further disability tracking action is necessary.
QCM – Suspended	A sanction decision (such as for failure to attend a medical examination) has been issued which suspends disability management actions. If the SRO code is entered, DM tracking resumes and the record reverts to the previous category code.
QCM – Removed from QCM	The DM record has been manually removed from tracking (e.g. it was created in error).
QCM – Expired	If no resolution has occurred within 30 months from the DM Track Date, the QCM record will expire.
PRM-Open	The DM record has been open 30 months or more past the DM Track Date and the claimant remains off work or is working with wage loss. The case will continue to be managed under PRM.
PRM - Working LD	The claimant has returned to work at less than full duty, but an LWEC decision has not been issued.
PRM – PN	A finding has been made that the claimant is entitled to payment on the periodic roll with no wage-earning capacity for the indefinite future (case status code PN).
PRM -LWEC	A formal loss of wage-earning capacity (LWEC) decision has been issued and the claimant is receiving payments on the periodic roll.
PRM – Suspended	A sanction decision (such as for failure to attend a medical examination) has been issued which suspends disability management actions. If the SRO code is entered, DM tracking resumes and the record reverts to the previous category code.
PRM - Remove from PRM	The DM record has been manually removed from tracking within the PRM universe of cases (e.g. it was created in error).
PRM – Complete	The claimant has returned to work full duty, returned to work with no loss in wage-earning capacity, a formal decision has been issued regarding the claimant's future entitlement (e.g. no injury-related disability, refusal of suitable work), or some other resolution code has been entered indicting no further entitlement to compensation (e.g. the claimant has elected retirement benefits). No further disability tracking action is necessary.

6. DM Codes. The DM record should be updated to reflect the actions taken to bring a DM case to resolution. Some DM codes are mandatory, while others are optional. The codes are described in more detail later in this chapter.

a. Mandatory Codes. There are five types of mandatory codes.

(1) CE Intervention Codes. These codes must be updated in the DM record whenever a CE actively intervenes in a case in an effort to bring a case towards resolution. See 2-0601-7 for a detailed discussion on CE intervention codes. The following are some situations when a mandatory CE Intervention code is required:

(a) a narrative report is requested from a physician;

(b) a second opinion examination or referee examination has been scheduled;

(c) a nurse extension has been granted;

(d) a case is opened for dual tracking with both field nurse services and vocational rehabilitation services;

(e) a ten-month letter has been issued; or

(f) a conference has been completed.

(2) Codes Reflecting a Nurse or Vocational Rehabilitation Status Change. When a Field Nurse (FN) or Rehabilitation Counselor (RC) is assigned to the case, a nurse or vocational rehabilitation case has been closed, or the status of a nurse or vocational rehabilitation case has changed, the appropriate codes must be updated by the Staff Nurse (SN) or Rehabilitation Specialist (RS) via the Nurse/Rehabilitation Tracking System (NRTS). When the codes are entered into NRTS, the DM record will auto-populate with the appropriate DM code. See paragraph 2-0601-8 below for a detailed discussion of nurse intervention codes; see 2-0601-10 for a detailed discussion of vocational rehabilitation program codes.

(3) Return-to-Work Codes. When a claimant returns to work, the appropriate RTW information should be entered via the Work Status Tracking tab in the DM record. The RTW information should document the claimant's work schedule, his or her work capacity, and the effective date of the claimant's return to work. See paragraph 2-0601-11 for a detailed discussion of RTW codes.

(4) Closure Codes. Whenever a case is resolved other than through the claimant's return to full duty, the DM record should be closed using the appropriate closure/resolution code. See paragraph 2-0601-13 for a detailed discussion of QCM/PRM resolutions.

(5) Suspension Codes. If compensation is suspended for any reason, the DM record should be updated with the appropriate suspension code. However, when the claimant satisfies his or her burden and entitlement

resumes, the DM record should be reopened with the appropriate code. See paragraph 2-0601-13.

b. Optional Codes. Optional codes are not required; however, entering these codes provides a detailed explanation of the progression of a DM case and can assist the CE with management of the case. Optional codes are useful not only to clarify the past management of a case, but also to indicate what further actions may be necessary. See paragraph 2-0601-12 for a detailed discussion of optional codes.

c. RMV Code. When a DM record is created erroneously, the case must be removed from DM using code RMV. This code should only be used when a case was placed into DM Tracking in error. Valid DM cases should not be removed from DM via the RMV code. If the reason is not clear, sufficient explanation should be given in the record to explain why the case was removed from DM using this code. This explanation may be documented by updating the notes section in DM Tracking.

Note - In some situations, the RMV code is automatically populated based on other codes that are entered.

7. CE Intervention Codes. Codes should be updated in the DM record whenever a CE actively intervenes in an effort to bring a case towards resolution. The following mandatory codes should be entered into DM Tracking by the CE:

a. **CON** (Conference Completed). This code should be used for both formal and informal conferences, but it should only be used when the conference pertains to the DM aspects of the case, e.g. this code should not be added to DM Tracking if a conference was held with regard to an overpayment. The effective date of the status is the date of the conference.

b. **OIC** (Other Intervention by CE). Used when the CE contacts the claimant or Employing Agency (EA) to discuss a RTW date and/or the availability of limited duty. This code may be used more than once in a given DM record, but it may not be used when the conversation concerns bill payment, compensation payment, or other case issues not specific to disability management. The OIC intervention should be focused on RTW. The effective date of the status is the date of the letter or telephone conversation. It may be used in the following instances:

(1) The CE contacts the claimant to specifically discuss return to work issues. Topics would include the anticipated return to work date (for either regular or light duty); current work limitations and why they preclude any work at all, or preclude return to the claimant's regular job; and whether the claimant has contacted the employer about the availability of light duty. This type of contact will usually occur by telephone and should be documented in the file via a CA-110 (or equivalent). The conversation should be substantive and serve to remind the claimant of his or her responsibility to return to work.

(2) The CE contacts the EA to discuss work limitations or the availability of light duty, or to solicit a job offer. If the claimant has been released to work, the description of work limitations should be available on the date of the contact. If the use of OIC is based on a telephone call, the CE should fully document the conversation in a CA-110 (or equivalent).

c. **MSI** (Second Opinion Scheduled). The effective date of the status is defined as the date of the second opinion examination (a date in the future is allowed). This code should not be entered when a case is referred for a second opinion evaluation; rather, it should be entered once the appointment date has been set.

d. **MRI** (Referee Exam Scheduled). The effective date of the status is defined as the date of the referee examination (a date in the future is allowed). This code should not be entered when a case is referred for a referee evaluation; rather, it should be entered once the appointment date has been set.

e. **QAP** (Narrative Report Requested from Physician). Used when the CE poses written questions to the attending physician about the extent and duration of disability, work tolerance limitations or the claimant's ability to work, current treatment plan to facilitate medical recovery, etc. The effective date of the status is the date of the letter.

f. **SRO** (Suspension Reopened). If the claimant's compensation has been suspended for obstruction of the rehabilitation effort (SUC), obstruction of a medical examination (SUM), or failure to return Form CA-1032 (SUE), and compensation is later reinstated, code SRO is required. The effective date of the status is the date of that compensation was reinstated.

g. **TML** (Ten Month Letter Issued). A primary goal of disability management is to return the claimant to work as soon as possible, but particularly within one year of the onset of disability. This one-year deadline is significant because section 8151(b) of the FECA requires the EA to offer the claimant his or her former position or its equivalent if the injury or disability has been fully overcome within one year. If the claimant has not returned to work on a full-time basis, the claimant should be reminded of his or her retention rights and the CE should send such a letter by 10 months post Track Date (though it can be sent sooner). The effective date of the status is the date this letter is sent.

8. **Nurse Intervention Codes**. Nurse intervention codes are used to document actions throughout the Nurse Intervention phase of DM. These codes document actions with regard to both the COP Nurse and the Field Nurse. The following are the mandatory codes pertaining to Nurse Intervention. Some are automatic and others must be entered manually.

a. COP Nurse (CN) Codes.

(1) **NCP** (Referred to COP nurse). This code is auto-populated from the date of assignment of the COP Nurse in NRTS.

(2) **TCC** (Triage COP Case). New traumatic injury claims are eligible for assignment to a COP Nurse seven (7) days after the claimant stops work (based on the data contained on the CA-1). If a return to work date has been entered into iFECS prior to assignment of a CN, the case will not be eligible for assignment. For eligible cases though, the TCC code is auto-populated using the "current" date to create an open DM record in the system. No LPD count during this period.

(3) **TCQ** (QCM – Triage to QCM – Open). Once 45 days from the date of injury have elapsed, if no return to work full-time code has been entered in

DM Tracking, the status code TCQ is auto populated via a nightly run and the category changes to QCM - Open. The Start date and Track date are populated with the date the record is changed to QCM Open, and LPDs start to count. If the claimant has returned to part-time work, the category changes to QCM-Working LD and LPDs count partial days.

(4) **TRC** (Closed – Triage case with Full Time RTW during COP). If a full-time return to work date is entered in the DM record within 45 days of the date of injury, code TRC is auto-populated and the category is changed to QCM - Resolved Triage. Additional codes are not allowed after entry of TRC; therefore, if the CE wishes to track a full-time light duty return to work and assign a FN, a new DM record will need to be manually created. No LPD count in these cases and they are not considered as resolutions for QCM. Return to work activity and success during the COP Nurse phase of a case is assessed based primarily on the coding in NRTS.

b. Field Nurse (FN) Codes.

(1) **NSN** (Referred to Staff Nurse). The date the CE completes the referral to the Staff Nurse (SN). This code auto-populates to the DM record when the referral is completed in the Case Referral application in iFECS.

(2) **NFN** (Referred to Field Nurse). The date the SN makes the assignment to the FN. This code is auto-populated from the SN's assignment action made in NRTS.

(3) **NF3** (30-Day Nurse Extension Granted). If the claimant has not returned to work in a full-duty capacity and there is something specific the FN can do within 30 days to further the return to work effort, the CE can extend nurse services for 30 days. There must be a clear indication that FN services would be useful for a specific purpose, and the case record must clearly document that purpose and that direction has been provided to the FN. After 30 days, if an additional extension is needed, the same justification and documentation are necessary to approve an additional 30-day extension.

No justification for a 30-day extension is needed if the claimant has returned to work and the extension is for monitoring that effort (60 days for light duty and 30 days for full duty); however, the extension coding should still be entered in the DM record. Refer to FECA PM 2-0811-10 for additional details about granting extensions during the FN assignment period.

(4) **NF6** (60 Day Extension Granted). Just as with the 30-day extension, if the claimant has not returned to work in a full-duty capacity and there is something specific the FN can do within the next 60 days to further the return to work efforts, the CE can extend nursing services for 60 days. There must be a clear indication that FN services would be useful for a specific purpose, and the case record must clearly document that that purpose and that direction has been provided to the FN.

No justification for a 60-day extension is needed if the claimant has returned to work and the extension is for monitoring that effort (60 days for light duty); however, the extension coding should still be entered in the DM record.

Refer to FECA PM 2-0811-10 for additional details about granting extensions during the FN assignment period.

(5) **NCO** (Nurse Case Closed). The initial nurse assignment is 120 days, regardless of whether the claimant has returned to light-duty work or not. A shorter assignment may be considered if the claimant has already returned to light-duty work. The initial assignment period can be extended consistent with the guidance provided in FECA PM 2-0811-10. Supervisory approval is necessary for extensions past 180 days unless the claimant returns to work during an initial extension period and the return to work monitoring period (60 days for light duty and 30 days for full duty) will exceed the 180 days. When FN intervention has ended, though, the NCO code is required. This code is auto-populated from the SN's closure action in NRTS.

9. Dual Tracking Codes. During the Nurse Intervention period, the CE has the option to dual track certain cases. Dual tracking is when both a FN and RC are assigned to a case at the same time. Refer to FECA PM Chapter 2-0600-8, 2-0600-9, 2-0811-11 and 2-0813-5. Both dual tracking codes are mandatory, and both must be entered manually by the CE.

a. **DTO** (Dual Track Opened). This code is entered when it is determined that a case would benefit from dual tracking with a FN and a RC on the case at the same time. Since a FN will already be assigned to the case when dual tracking is initiated, code DTO should be entered when the RC is also assigned to the case.

b. **DTC** (Dual Track Closed). This code is entered when dual tracking is no longer needed. If the case is closed for Nurse Intervention, but the RC remains on the case, the DTC code should be entered when the FN is closed. If the RC is closed, but the FN remains on the case, the DTC code should be entered when the RC is closed.

Note – If the claimant returns to work as a result of dual track intervention, the RTW code (discussed later in this chapter) must be entered prior to the DTC.

10. Vocational Rehabilitation Intervention Codes. A few codes are manually entered by the CE in DM to reflect vocational rehabilitation actions. However, most codes relating to vocational rehabilitation efforts are auto-populated into DM by coding entered by the RS in the NRTS application. The following are the mandatory codes pertaining to Vocational Rehabilitation.

a. Rehabilitation Referral Codes.

(1) **RHR** (Referred to Rehabilitation Specialist). This code is auto-populated into DM the date the CE completes the Vocational Rehabilitation referral in the Case Referral application in iFECS.

(2) **RRC** (Referred to Rehabilitation Counselor). This code is triggered by the date the RS makes the assignment to the RC. This code is auto-populated from the RS's assignment action in NRTS.

b. Plan Development Codes.

(1) **RHD** (Plan Development). When code D is entered into NRTS, status code RHD is populated into DM.

(2) **RHI** (Rehabilitation Plan in Place). When code I is entered into NRTS, status code RHI is populated into DM. In addition, an iFECS reminder is sent to the CE to send a letter advising the claimant of the eventual reduction of compensation as the result of rehabilitation efforts.

(3) **RLT** (Eventual Reduction via Rehabilitation - letter sent by CE). This code is manually entered into DM by the CE when the appropriate letter is issued to the claimant.

c. Placement Previous Employer Codes.

(1) **RHN** (Placement Previous Employer – Without Other Services). When code N is entered into NRTS, status code RHN is populated into DM.

(2) **RHW** (Placement Previous Employer – With Other Services). When code W is entered into NRTS, status code RHW is populated into DM.

d. Training and Placement New Employer Codes.

(1) **RHT** (In Approved OWCP Vocational Training). When code T is entered into NRTS, status code RHT is populated into DM. This code does count as a QCM resolution.

(2) **RHP** (Placement New Employer). When code P is entered into NRTS, status code RHP is populated into DM.

(3) **RHS** (Self-Employment). When code S is entered into NRTS, status code RHS is populated into DM.

e. Assisted Re-employment Codes.

(1) **RHG** (Assisted Re-employment Program). When code G is entered into NRTS, status code RHG is populated into DM.

(2) **RHV** (Employed, Assisted Re-employment Program; RC Follow-Up). When code V is entered into NRTS, status code RHV is populated into DM.

f. Employment Codes.

(1) **RHE** (Employed). When code E is entered into NRTS, status code RHE is populated into DM. (The CE will still need to enter the RTW information in the Work Status tracking tab in the DM record.)

(2) **RHZ** (Post-Employment Services). When code Z is entered into NRTS, status code RHZ is populated into DM.

g. Codes related to Medical Issues and Interruption of Services.

(1) **RHM** (Medical Rehabilitation). When code M is entered into NRTS, status code RHM is populated into DM.

(2) **RHX** (Vocational Rehabilitation Services Interrupted). When code X is entered into NRTS, status code RHX is populated into DM.

h. Closure and Suspension Codes.

(1) **RCL** (Rehabilitation case closed with no RTW). When the rehabilitation case is closed with code 5 in NRTS, status code RCL is populated into DM.

(2) **RHC** (Returned to Claims Examiner). When code C is entered into NRTS, status code RHC is populated into DM.

(3) **RWL** (Rehabilitation non-cooperation 30-day warning letter). This code is manually entered into DM by the CE effective the date the letter is issued.

i. Schedule A Initiative Codes. DFEC's initiative to utilize the Schedule A non-competitive hiring authority to help rehire injured federal workers back into the federal government occurs during vocational rehabilitation. Codes related to the Schedule A Initiative must be entered into NRTS by the RS and then, upon notification, the CE manually enters the appropriate code in DM, as described below.

(1) **SCI** (Schedule A Identified). When the RS identifies a claimant who may be a suitable candidate for Schedule A placement, he or she will make a referral to the Schedule A RS for review. The RS will then code the case in RTS as AI (Schedule A Identified) and notify the CE so that SCI can be added to DM.

(2) **SCC** (Schedule A Certified). When a claimant wishes to participate in Schedule A placement services, in addition to the usual rehabilitation placement services for a job in the private sector, the Schedule A RS prepares a disability certification letter and enters code AC into NRTS and notifies the CE so that SCC can be added to DM.

(3) **SCR** (Schedule A Rejected). When a claimant is not a good candidate for Schedule A placement services the Schedule A RS enters code AR into NRTS and notifies the CE so that SCR can be added to DM.

(4) **SCD** (Schedule A Services Declined). When a claimant indicates that he or she does not want to proceed with Schedule A placement services, the RS enters code AD into NRTS and notifies the CE so that SCD can be added to DM.

(5) **SCW** (Schedule A RTW). When the claimant returns to work via the Schedule A hiring authority and the case record is documented with the specifics of the RTW, the RS enters code AW into NRTS and alerts the CE so that SCW can be added to DM. Note - Along with the Schedule A disposition code, the RS enters the usual NRTS codes to document the RTW. The CE then enters the usual RTW codes in DM to appropriately reflect the RTW via rehabilitation and to change the DM category. See paragraph 2-0601-11 for a discussion of updating RTW codes.

(6) **SCO** (Schedule A RTW Other). When the claimant returns to work without the use of the Schedule A hiring authority (after having been Schedule A Certified - SCC) and the case record is documented with the

specifics of the RTW, the RS enters code AO into NRTS and alerts the CE so that SCO can be added to DM. Along with the Schedule A disposition code, the RS enters the usual NRTS codes to document the RTW. The CE enters the usual RTW codes in DM to appropriately reflect the RTW via rehabilitation and to change the DM category. See paragraph 2-0601-11 for a discussion of updating RTW codes.

(7) **SCN** (Schedule A Closed - No RTW). When the vocational rehabilitation placement period ends for a case in which the claimant was Schedule A certified (SCC) and there was no RTW, the RS enters code AN into NRTS and notifies the CE so that SCN can be added to DM.

11. Return to Work (RTW) Codes. RTW codes are used to indicate a return to work during DM. All RTW codes are mandatory. **In order to use RTW codes, the claimant must actually return to work; a release to return to work without an actual return to work is not sufficient for use of RTW codes.**

These codes should be entered in the DM Work Status Tracking tab. Although RTW codes may be manually entered in DM Tracking by adding the specific status, this method of entering the code may not result in the proper tracking of LPD and should not be used. The specific hours and days worked should be entered on the Work Status Tracking tab, and the source should be identified as the CE, the FN, or the RC.

Any additional information regarding the job offer can also be entered on the Work Status Tracking tab. Information regarding the job offer, salary, the claimant's response, the suitability determination, the claimant's response to the suitability decision, and the CE's decision should be entered as appropriate.

The following are brief descriptions of each RTW code and the process for entering the codes in the DM record. Refer to FECA PM 2-0600 for additional details regarding case management actions surrounding a RTW.

a. Pre-DM RTW Codes.

(1) **PFP** (Pre-DM RTW Full Duty/Part-Time). Used when the claimant returns to full-duty work on a part-time basis before the DM record is created. This code begins counting LPDs at a fraction.

(2) **PLF** (Pre-DM RTW Light Duty/Full Time without wage loss). Used when the claimant returns to full-time light duty work before the DM record is created. This code prevents LPDs from counting.

(3) **PLP** (Pre-DM RTW Light Duty/Part Time). Used when the claimant returns to light duty part-time work before the DM record is created. This code begins counting LPDs at a fraction.

(4) **PL$** (Pre-DM RTW Light Duty/Full Time with wage loss). Used when the claimant returns to full-time, light-duty work with wage loss before the DM record is created. This code prevents LPDs from counting.

b. Nurse RTW Codes.

(1) **NFF** (RTW via Nurse DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via nurse services. This RTW code stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution. No further codes can be entered after this RTW code.

(2) **NFP** (RTW via Nurse Full Duty/Part Time). Used when the claimant returns to part-time, full-duty work via nurse intervention. This code starts counting LPDs at a fraction.

(3) **NLF** (RTW via Nurse Light Duty/Full Time without wage loss). Used when the claimant returns to full-time, light-duty work via nurse services. This code stops counting LPDs.

(4) **NLP** (RTW via Nurse Light Duty /Part Time). Used when the claimant returns to part-time, light-duty work via nurse intervention. This code may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the nurse. This code causes LPDs to be counted at a fraction.

(5) **NL$** (RTW via Nurse Light Duty/Full-Time with Wage loss). Used when the claimant returns to full-time, light-duty work with wage loss via nurse services. This code stops counting LPDs.

c. Vocational Rehabilitation RTW Codes.

(1) **RFF** (RTW via Rehab DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via rehabilitation services. This RTW code stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution. No further codes can be entered after this RTW code.

(2) **RFP** (RTW via Rehab Full Duty/Part Time). Used when the claimant returns to part-time, full-duty work via rehabilitation services. This code starts counting LPDs at a fraction.

(3) **RLF** (RTW via Rehab Light Duty/Full Time without wage loss). Used when the claimant returns to full-time, light-duty work via rehabilitation services. This code stops counting LPDs.

(4) **RLP** (RTW via Rehab Light Duty/Part Time). Used when the claimant returns to part-time, light-duty work via rehabilitation services. This code may also be used in cases that already have a PLP code, but only if the work hours actually increase due to intervention by the RC. This code starts counting LPDs at a fraction.

(5) **RL$** (RTW via Rehab Light Duty/Full Time with Wage Loss). Used when the claimant returns to full-time, light-duty work with wage loss via rehabilitation services. This code stops counting LPDs.

d. DM RTW Codes without Nurse Intervention or Vocational Rehabilitation. To use these codes, the CE's intervention should be readily identifiable, **and these**

codes should only be used if a FN or RC is not assigned at the time of the RTW.

(1) **CFF** (RTW via CE DOI or Pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position with CE intervention. This RTW code stops counting LPDs. This type of RTW is also considered a closure code and a QCM/PRM resolution if there are prior DM intervention codes. No further codes can be entered after this return to work code.

(2) **CFP** (RTW via CE Full Duty/ Part Time). Used when the claimant returns to full-duty work on a part-time basis with CE intervention. This code starts counting LPDs at a fraction.

(3) **CLF** (RTW via CE Light Duty/Full Time without wage loss). Used when the claimant returns to light-duty work on a full-time basis with CE intervention. This code stops counting LPDs.

(4) **CLP** (RTW via CE Light Duty/Part Time). Used when the claimant returns to part-time work with CE intervention. This code may also be used in cases where a PLP code is already used, but only if the work hours actually increase through the CE's intervention. This code begins counting LPDs at a fraction.

(5) **CL$** (RTW via CE Light Duty/Full Time with Wage Loss). Used when the claimant returns to light duty on a full-time basis with wage loss with CE intervention. This code stops counting LPDs.

(6) **CPS** (RTW via CE in the Private Sector). Used when a claimant returns to work in the private sector with CE intervention. This code stops counting LPDs.

12. <u>Optional Codes</u>. Optional codes provide a detailed explanation of the progression of a DM case. Optional codes are useful not only to clarify the past management of a case, but to help decide what further actions may be necessary to bring a case to resolution. These codes cannot be entered as a substitute for mandatory intervention codes. Optional codes should be used in conjunction with the mandatory codes to fully document the management of a case. Below is a list of optional codes and an explanation of their use. All of these codes must be manually entered into the DM tracking system.

a. **IAE** (Interim Actual Earnings). IAE can be entered if the claimant is being paid for a LWEC based upon actual earnings, but a formal decision has not been issued. This code is useful for alerting the CE to review the case for a possible formal decision regarding an LWEC. The effective date of code IAE should be the date the first LWEC payment is certified.

b. **JOB** (Job Offer Made). JOB can be entered when a job offer is made to the claimant. This code is useful for alerting the CE that a follow-up action may be necessary, such as determining the suitability of the job offer. The effective date of code JOB should be the date that the job is actually offered to the claimant.

c. **JOL** (Suitable Job Offer Letter Issued). JOL can be entered when the job offer suitability determination is sent to the claimant. The code can be used for both

the 30-day letter and the 15-day letter. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

d. **JOR** (Job Offer Request / Work Restrictions to EA). JOR can be entered when the CE solicits a job offer from the EA. This code is useful for alerting the CE that a follow-up action may be necessary. The effective date of code JOR should be the date that the job offer is actually requested.

e. **JOW** (Job Offer Withdrawn). JOW can be entered when a job offer is withdrawn from the claimant. This code is useful for alerting the CE that further intervention is necessary. The effective date of code JOW should be the date the job offer was actually withdrawn.

f. **MIN** (Medical Interruption of DM Activity). MIN can be entered if there is a non-work-related medical condition that is delaying the disability management of a case. This code is useful to document when there are non-work-related medical issues that prevent active intervention in a case, and to alert the CE to frequently review the medical evidence in the case. The effective date of code MIN should be the date the CE determines that disability management must be delayed.

g. **MNR** (Narrative Report Received). MNR can be entered if a narrative medical report is received from the claimant's attending physician that provides substantial information regarding the claim. Usually, this code should be used when a narrative report is submitted in response to a request from OWCP (after the entry of the QAP code) and the CE has reviewed this medical evidence. The effective date of code MNR should be the date the specific narrative report is received.

h. **MSC** (Second Opinion Report Received). MSC can be entered when the CE receives a second opinion examination report. It is useful to alert the CE that a follow-up action may be necessary. The effective date of the MSC code should be the date the report is received.

i. **MSF** (Second Opinion Follow-up Taken). MSF can be entered when the CE follows up with the second opinion examiner after receiving a second opinion examination report. This code is useful for alerting the CE to follow up if the information requested is not received in a timely fashion. The effective date of code MSF should be the date the follow-up action is taken.

j. **MRC** (Referee Report Received). MRC can be entered when the CE receives a referee examination report. It may be useful to alert the CE that a follow-up action may be necessary. The effective date of the MRC code should be the date the report is received.

k. **MRF** (Referee Follow-up Taken). MRF can be entered when the CE follows up with the referee examiner after receiving a referee examination report. This code can be used to alert the CE to follow up if the information requested is not received in a timely fashion. The effective date of code MRF should be the date the follow-up action is taken.

l. **OPM** (Elected OPM benefits). OPM can be entered if the claimant has elected Office of Personnel Management (OPM) benefits. The effective date of code OPM should be the effective date of the OPM election. Note - Code CSB will be needed to

actually close out the DM record once appropriate case management actions have been completed.

m. **PRL** (Pre-reduction notice sent). PRL can be entered when a proposed notice of reduction is sent to the claimant. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

n. **PTL** (Pre-termination notice sent). PTL can be entered when a proposed notice of termination is sent to the claimant. This code is useful for alerting the CE that a follow-up action is necessary so that a final decision can be reached.

o. **SUR** (Surgery Authorized). SUR is entered when the claimant has approved surgery. This code is useful for alerting the CE to re-evaluate the disability management options for this case. The effective date of code SUR should be the date the surgery is authorized (since entry of a future date is not allowed). The CE may adjust this date to the date of the actual surgery once the surgery takes place.

p. **TTD** (Continuing Total Disability per Secop/Referee). TTD can be entered when a second opinion or referee examination report substantiates that the claimant is temporarily totally disabled due to his or her accepted work injury and the condition is not expected to improve within the foreseeable future. This code may not be used if a second opinion or referee specialist has not provided such an opinion, unless the case is catastrophic in nature. This code should be documented with a memo to file.

13. Closure Codes and Resolutions. Certain DM status codes when entered into DM Tracking serve to close the period of disability being tracked. These closure codes may reflect the claimant's return to full-duty work, a return to modified work with a formal LWEC decision, a termination for no continuing disability or failure to accept suitable employment, a recurrence, or election of other benefits. There should always be documentation in the file to support the closure code used and its effective date.

Some codes are considered successful resolutions for both QCM and PRM, while some outcomes are only considered a resolution for QCM cases and others only a resolution for PRM. Note below where those distinctions have been made, showing whether a particular code is considered a resolution for QCM only, PRM only, or both QCM and PRM. Resolution of DM cases is discussed further in FECA PM 2-0600. Further discussion of PRM resolutions can be found in FECA PM 2-0812.

a. RTW to Date of Injury or Pre-Established LWEC Job. The effective date of the code is the actual RTW date. In order to use these codes, the claimant must actually return to work; a release to return to work without an actual return to work is not sufficient for use of these codes. These closure codes will count as a QCM or PRM resolution, though NFF would be rarely seen in a PRM case.

(1) **CFF** (RTW via CE DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position without nurse intervention or vocational rehabilitation (services closed when the return to work occurs). Prior CE DM intervention coding is required.

(2) **NFF** (RTW via Nurse DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via nurse services.

(3) **RFF** (RTW via Rehab DOI or pre-established LWEC Job). Used when the claimant returns to work at the date of injury or pre-established LWEC position via rehabilitation services.

b. RTW to a modified or new job with LWEC decision. If the claimant returns to work in less than a full-duty capacity, entry of the RTW code will stop the LPDs from counting (or counting fully in part-time RTW cases) if the return to work occurs within the first year of disability. The record will remain open, however, until an appropriate resolution code is entered. This typically requires issuing a formal LWEC decision. The effective date of these LWEC-related closure codes will be the date of the LWEC decision issued. These closure codes will count as a QCM or PRM resolution.

(1) **CAE** (RTW, actual Earnings LWEC). This code should be used when the claimant has permanent or stable and well defined work restrictions stemming from the work injury, has returned to a new position or modified version of the date of injury position, and OWCP has issued a formal LWEC decision based on the claimant's actual earnings, with wage loss. While this code is considered a resolution for both QCM and PRM cases, if entered in the QCM period the DM category changes to PRM – LWEC and the case remains active in the PRM universe, since the claimant is still receiving monetary compensation.

(2) **CNL** (RTW, not DOI job with 0% LWEC Decision). This code should be used when the claimant has permanent or stable and well-defined work restrictions stemming from the work injury, has returned to a new position or modified version of the date of injury position, and OWCP has issued a formal LWEC decision based on no wage loss.

c. RTW to a modified or new job with no LWEC decision possible. This closure/resolution code is only for cases in the QCM universe.

(1) **CNC** (RTW in non-classified position). This code is used if a formal LWEC decision cannot issued, but the claimant's work restrictions have reached a permanent or stable and well-defined state. This is usually due to the job being a non-classified position or a position that is not permanent in nature. As the effort to obtain a permanent job offer should not be abandoned prematurely, the code should usually not be entered earlier than 2 years from the Track Date unless extenuating circumstances exist. A memorandum to file is required to explain the use of the code for the specific case. The effective date of this code is the date of the memorandum, and it counts as a QCM resolution only. Since entry of this code closes the QCM record, it should not be entered if the claimant has continued wage loss and is receiving benefits on the periodic roll.

If the claimant continues to receive wage-loss compensation on the periodic roll in this situation (e.g. if the claimant is working only part time), a memorandum to the file is still required; however, code CAE should be used

(not CNC) so that the case continues to track in the PRM universe since wage-loss compensation is being paid.

d. No actual RTW but medically able to RTW. Compensation entitlement is reduced. This closure code counts as a QCM or PRM resolution.

(1) **CLW** (Constructed LWEC Decision). This code should be used when the claimant has permanent or stable and well-defined work restrictions stemming from the work injury and has participated in vocational rehabilitation with an unsuccessful placement effort. The claimant is rated based on a position identified by the RC as one that is suitable, readily available, and within the claimant's capabilities. A final reduction decision is issued, reducing the claimant's entitlement with a formal constructed LWEC decision, based on the wages of the selected position identified. This code is considered a resolution in both QCM and PRM cases, but if entered during the QCM period, the DM category changes to PRM – LWEC and the case remains in the PRM universe if the claimant continues to receive wage-loss compensation. The effective date of this code is the date of the final decision.

e. No compensable disability from work. Claimant's entitlement to wage loss and/or medical benefits due to the work injury has been terminated. This closure code counts as a QCM or PRM resolution.

(1) **CCO** - (Benefits Terminated, no continuing injury-related disability). This code should be used when the claimant's work-related condition no longer prevents him or her from returning to the job held on the date of injury. In some cases, the work-related condition has resolved completely, while in other cases there are still residuals of the work-related condition but those residuals do not prevent the claimant from being able to return to the date of injury job. The claimant has no ongoing entitlement to compensation for wage loss once the medical evidence establishes the ability to perform the duties of the date of injury position. A formal decision denying ongoing disability wage-loss compensation, medical benefits, or both is issued. The effective date will be the date of the final decision.

f. Sanctions. Most sanctions can close a DM record under QCM or PRM and count as a resolution, but the **SUE** code does not count as resolution in either QCM or PRM.

(1) **CFC** (Fraud Termination, against OWCP/US Government). This code is used when a formal decision is issued terminating entitlement to compensation because of a fraud conviction. The effective date for this code will be the date of the Section 8148 decision.

(2) **CRC** (Reduction – Incarcerated due to Felony). This code should be used when a claimant is incarcerated due to a felony conviction that is not related to fraud against OWCP/US Government. Benefits are reduced according to the status of the claimant's dependents. The effective date for this code will be the date compensation is reduced.

(3) **CSA** (Sanctions for refusing suitable work, Section 8106). This code should be used when a claimant is offered suitable employment within his or her medically-imposed restrictions and refuses the job offer. The claimant

has no ongoing entitlement to compensation for continuing disability, since he or she refused a suitable offer of employment commensurate with his or her work capacity. A formal decision is issued and the claimant's entitlement to wage loss and a schedule award is terminated. The effective date will be the date of the final decision.

(4) **SUC** (Suspension of Compensation for Rehab Non-Cooperation). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

(5) **SUE** (Suspension of Compensation for No Report of Earnings/ Dependency - CA-1032). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

(6) **SUM** (Suspension of Compensation for Obstruction of Medical Examination). The effective date for this code will be the date of the decision. The DM record may be reopened later with code SRO.

g. Claimant in an approved vocational rehabilitation training program.

(1) **RHT** (In Approved OWCP Vocational Training). This code populates in DM Tracking when the RS enters code T into NRTS. Because a vocational rehabilitation training program can last for several months, but is intended to result in a return to work, this code does count as a QCM resolution if present at the 30-month mark. It does not, however, count as a PRM resolution.

h. Claimant Unable to Work or No Change in Benefit Level. There are instances when it is determined that the claimant is unable to work due to the severity of the injury.

(1) **CPN** (Permanent Total Disability Determination). This code should be used when the claimant is found to have no wage-earning capacity or re-employment potential for the indefinite future and the case is placed in a PN status. A memorandum to the file is required to document the reason(s) for this determination, and the memorandum must document concurrence from a Supervisory Claims Examiner. See FECA PM 2–0812. Since this is not a successful QCM resolution, this should only be used for the most serious injuries while the disability case is still within the first 30 months. The effective date for this code will be the date of the PN memo. Entry of CPN in a QCM record changes the category to PRM-PN. This code does not count as a resolution for either QCM or PRM.

(2) **PCR** (No entitlement change following PR review). This code should be used when the factual and medical evidence in the file clearly reflect that the current benefit level is appropriate. The file must be documented with a memorandum to the file. See FECA PM 2-0812 for a sample of this memorandum. If a PN recommendation occurs simultaneously with the use of the PCR code, the same memorandum can be used for both purposes. This code is only applicable for cases in the PRM universe and can only be used once every five years.

i. Recurrence of Disability. If the claimant sustains a recurrence of total disability, new injury, or increase in disability following a return to light duty, this

new work stoppage should be reflected in the DM record. If the recurrent disability is due to the same injury, a new DM record should be created in that case after the current record is closed. If the recurrent disability is due to a new injury, then the current DM record should be closed and a new DM record should be opened under the new injury case file.

(1) **CRN** (Recurrence/New Injury Following RTW Light Duty). This code should be used when the claimant sustains a recurrence or a new injury during the QCM period. In addition to new work stoppages due to the injury, any increase in disability from work may lead to a CRN code, such as when the claimant decreases his or her working hours from eight to four. CRN should not be used in a PRM case; CRL is the recurrence code for PRM cases (see below).

Note - Timely identification of a work stoppage or an increase in disability is essential. DM Tracking does not allow this information to be entered at a later date, especially if the claimant has already returned to work since the increase in disability. When coding DM with a code CRN, it is also important to properly notify the SN and FN if nurse intervention is still active. The new work stoppage and DM record will re-set the clock and allow the FN a new intervention time frame.

Cases closed with this code will be considered resolved successfully only if an earlier RTW occurred due to QCM intervention (as shown by status codes CLP, CL$, CLF, NLP, NL$, NLF, RLP, RL$, or RLF). If the prior RTW was a PLP, PL$, or PLF, the DM Tracking System will code the DM record RMV and remove the case from the QCM universe when the CRN code is entered.

(2) **CRL** (Recurrence, LWEC Modification – TTD). This code should be used when a recurrence occurs or a formal LWEC decision is modified to accept temporary total disability. PRM disability management is considered complete, but the system will initiate a request to create a new DM record to track the new period of total disability as a QCM case. This code is used only in PRM cases, but it does not count as a resolution.

j. Election of Benefits or Compensation No Longer Claimed. The DM record may also be closed when the claimant elects to receive benefits from the Office of Personnel Management (OPM) in lieu of OWCP benefits, elects increased disability benefits from the Department of Veterans' Affairs (DVA) in lieu of FECA benefits, or when the claimant has not claimed compensation.

(1) **CSB** (Compensation Not Claimed). This code is used in conjunction with the OPM code when a claimant elects OPM benefits. This code is also appropriate when a claimant has elected to receive increased VA disability benefits in lieu of FECA benefits. In situations other than an OPM or VA election, there should be a memorandum to the file to explain the use of this code. This code will count as a resolution for both QCM and PRM.

k. Death of the Claimant.

(1) **DEA** (Death of Claimant). This code is used whenever a claimant who has an active DM record dies. The effective date of the code is the date of

death. This code will close a QCM or PRM case, but it does not count as a resolution in either instance.

14. Obsolete Codes. Some DM codes have become obsolete and are no longer used; therefore, when reviewing previous coding in a DM record, some codes (and descriptions) may appear that are no longer available for use.

2-0700 DEATH CLAIMS

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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 (1ECAB 95), and Rose Martin, claiming as widow of Bruce Martin (24 ECAB 243).

c. Employing Agency. Section 5 U.S.C. 8128 requires the employing agency to report to OWCP any injury resulting in death, and to provide such supplementary reports as OWCP may require. The agency should be asked to assist in compiling and submitting evidence required from the claimant and witnesses except where adjudication occurs long after the decedent has been removed from the agency's rolls, and the agency no longer retains records of the decedent's employment. The claimant or OWCP must obtain statements from witnesses no longer on the agency's rolls.

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 5U.S.C. 8101(17)].

(1) A "year of education beyond the high school level" is defined as:

(a) The 12-month period beginning the month after the child graduates from high school, if the child has indicated an intention to continue in school during the next regular session, and each successive 12-month period, provided that school attendance continues.

(b) The 12-month period beginning on the date the child actually enters school to continue education, if the child has indicated that he or she will not attend during the next regular session, and each successive 12-month period, provided that attendance continues.

(2) A year of entitlement based on student status means any year during all or part of which compensation is paid based on school attendance. Therefore, if a beneficiary should decide for any reason not to attend school for part of a year during which benefits were paid on account of student status, that beneficiary would be charged with having used an entire year of eligibility out of the allotted four years, even though compensation terminates when the beneficiary leaves school. If a child has already completed one or two more years of college before turning 18, they would be deducted from the four years of entitlement.

(3) If the child does not begin post high school education immediately but later decides to enter school full-time, compensation would begin on the date school attendance began, as stated in (1)(b) above. In this situation, the individual would remain entitled to four years of compensation based on school attendance, provided he or she did not turn 23. In either case, compensation is continued during any interval between school terms if the interval does not exceed four months and if the beneficiary demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the beneficiary and decide what may be considered a period of reasonable duration during which compensation may be continued. The CE will also place a memorandum in the file outlining the circumstances of the case and the reasons for the decision. (See paragraph (7)(c) below concerning declarations of overpayments in these situations).

(5) The CE obtains proof of student status through the use of Forms CA-1615 and CA-1617. The CA-1615 should be forwarded to the dependent's parent or guardian at least three months before the dependent's 18th birthday. Where compensation is being paid for school attendance, Form CA-1617 should be sent twice each year at least two months prior to the date the current semester (or quarter, etc.) is scheduled to end. The CE should note on the CA-674 the number of years of eligibility remaining for each beneficiary based on student status.

(6) If the beneficiary is still receiving student benefits on turning 23, compensation should terminate at the end of that semester or enrollment period.

(7) Following are examples of common situations:

(a) John Smith's birth date is February 10, 1977. He has received compensation since 1983, and he will graduate from high school in May 1994. John has completed Form CA-1615 to indicate that he will attend college on a full-time basis starting in the fall of 1994. John's first "year of education beyond the high school level" will begin in June 1994, even though he is still entitled to benefits by virtue of being under 18 until February 1995.

(b) Steve Jones' date of birth is January 13, 1976. He received compensation beginning in 1984 and graduated from high school in June 1994. He completed Form CA-1615 to indicate that he would not attend college. He was entitled to receive compensation through June 1994, the month of his high school graduation (he was 18 when he graduated). Should Steve decide at some future date to continue his education, he would begin receiving compensation the month that he actually entered school and would be entitled to the entire four years of eligibility until he turns 23.

(c) Jane Doe's date of birth is April 15, 1974, and she received compensation beginning in 1988. She graduated from high school in May 1992 and indicated on Form CA-1615 that she would continue her education in the fall. Because of this evidence of a bona fide intent to attend school, her compensation was continued over the summer. In September she advised OWCP that she had reconsidered and decided to work instead of attending school.

Compensation was terminated effective October 1, 1992, without declaring an overpayment since 5 U.S.C. 8101(17) states that an individual "is deemed not to have ceased to be a student during an interim between school years if the interim is not more than 4 months and if he shows to the satisfaction of the Secretary that he has a bona fide intention of continuing to pursue a full-time course of study" during the following semester.

Since Jane received compensation after high school based on school attendance, the period for which she was paid represents one full year of eligibility out of her four year allotment. Had she decided at some future date to attend, she would have had three years of eligibility remaining. However, if she had decided to begin attending school in, for example, January 1993, she would still have been within her first year of eligibility, which began in June 1992 and ended in May 1993.

b. Marriage. A dependent child's eligibility for benefits terminates on the date of the child's marriage. A child whose marriage ended prior to the employee's death will not be barred from receiving survivor's benefits if otherwise entitled. A child whose marriage is annulled after the employee's death is eligible for survivor's benefits from the effective date of the annulment or the date of death (see FECA Program Memorandum No. 4) if otherwise entitled, but a child who is divorced or widowed is not eligible for benefits.

c. Children Over 18 Who are Incapable of Self-Support. When claims are made by or for children over 18 who are physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) Eligibility. To be entitled to benefits, a child over 18 at the time of the employee's death must have been incapable of self-support at the time of the death by reason of a mental or physical disability. Also, a child over 18 who becomes incapable of self-support after the employee's death, but before reaching 18, is eligible. A child over 18 is not entitled to benefits because of inability to obtain employment due to economic conditions, lack of job skills, etc.

(2) Definition. A claimant is incapable of self- support if his or her physical or mental condition is such that he or she is unable to obtain and retain a job, or engage in self-employment that would provide a sustained living wage. This determination must be based on medical evidence. When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by the sustained work performance.

(3) Medical Evidence. A medical report covering the child's past and present condition must be submitted and referred to the DMA to determine whether it establishes incapacity for self-support. A physician's opinion must be based on sufficient findings and rationale to establish unemployability.

d. Method of Payment. In death cases, payment of compensation is made to a child as follows:

(1) Under Age 18. Compensation will be paid to a parent, guardian, or other competent individual responsible for the child's welfare. If a child under age 18 without a parent, guardian or other individual responsible for supervision is found to be competent to receive payments, compensation can be paid directly to the child. Sources of information concerning competency include local juvenile authorities, school officials, police, and relatives. The CE should obtain information from such sources as well as any other pertinent evidence, then make a determination of competency. If necessary, the CE should ask juvenile authorities in the area of the child's residence to appoint a conservator.

(2) Students. Compensation will be paid directly to a child who is a student if he or she is of legal age in the state of residence. If not, and the parent or guardian requests payment of the compensation, the CE must determine whether direct payment of compensation would be in the child's best interest, based on factors in the specific case.

(3) Physically or Mentally Incompetent. On request, compensation will be paid directly to a child of legal age who is incapable of self-support due to physical disability. Compensation on behalf of mentally incompetent individuals must be paid to a parent, guardian, or other person responsible for the individual's welfare.

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.

2-0800-21 FECA Death Gratuity
21. FECA Death Gratuity.

The National Defense Authorization Act for Fiscal Year 2008, Public Law 110-181, amended the FECA, creating a new section 8102(a). The section establishes a new FECA benefit for eligible survivors of federal employees and Non-Appropriated Fund Instrumentality (NAFI) employees who die of injuries incurred in connection with service with an Armed Force in a contingency operation.

The new section 8102(a) states that the United States will pay a death gratuity of up to $100,000 to those survivors upon receiving official notification of the employee's death. Section 8102(a) also states that the United States will pay the death gratuity to the eligible survivors "immediately upon receiving official notification" of an employee's death. There is a retroactive payment provision, stating that the death gratuity will be paid for employees of certain agencies who died on or after October 7, 2001, due to injuries incurred in connection with service with an Armed Force in the theater of operations of Operation Enduring Freedom and Operation Iraqi Freedom. Regulations implementing the FECA death gratuity are set forth at 20 C.F.R. 10.900-916. The $100,000 death gratuity is offset and reduced by any other death gratuity paid for the same death.

All claims for benefits under 8102(a) will be processed by the Special Claims Unit in the Cleveland District Office. As a result, all claims for a death gratuity are to be transferred to Cleveland immediately upon receipt for handling and response. The original death claim, if applicable, should also be transferred to Cleveland at that time. Once received in Cleveland, each case will be assigned a specific claim number, beginning with the prefix "DG." A DG claim number will be assigned to each person making a claim. That means that more than one DG claim could be created as the result of one death. This also means that if a claim for a death gratuity is made in an existing FECA case, a new DG claim number will be assigned to the death gratuity – distinct from the existing FECA case number.

FECA death benefits payable under section 8133 and burial expenses payable under section 8134 of the Act do not constitute a dual benefit and, therefore, do not affect this FECA death gratuity payment made under section 8102(a).

More detailed procedures on processing these cases will be provided in Part 4 (Special Case Procedures) of the DFEC Procedure Manual.

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 INITIAL DEVELOPMENT OF CLAIMS

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Chapter 2-0800, Initial Development of Claims

1. Purpose and Scope. This chapter describes the fundamentals of claims development. Along with FECA PM 2-0801 through 2-0805, it covers the factors which all claims have in common. Initial acceptances are covered in FECA PM 2-0806 and formal denials are covered in FECA PM 2-1400. Additional material about death claims is covered in FECA PM 2-0700. The development of special act claims, in which entitlement is based on legislation extending FECA benefits to such groups as Peace Corps and VISTA volunteers, is described in FECA PM 2-1700.

2. Types of Claims. When a claim is submitted, it is classified based on the type of injury and the nature of injury. See Nature of Injury codes. (Exhibit 1)

a. Traumatic Injury (TI) -- a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable as to time and place of occurrence and member or function of the body affected. It must be caused by a specific event or incident or series of events or incidents during a single day or work shift. 20 CFR 10.5 (ee).

The following are examples of a traumatic injury: dog bite, knee strain after a trip and fall, neck strain after an auto accident, or a broken ankle after a slip on ice.

b. Occupational Disease (OD) -- a condition which is produced by continued or repeated exposure to elements of the work environment such as noxious substances or damaging noise levels over a period longer than one work day or shift. OD claims are classified as either basic or extended. 20 CFR 10.5(q).

(1) Basic OD -- Most claims for skin, orthopedic, viral, infectious, and parasitic diseases can be adjudicated with an initial request for information and perhaps a follow-up query for clarification. Some will clearly address all five basic requirements and may be adjudicated if all necessary evidence is in file. These cases are considered basic OD claims.

The following situations illustrate the kinds of cases which may be considered basic OD:

(a) A claim for poison ivy where the claimant's employment involves exposure to the plant, and the medical evidence confirms the diagnosis.

(b) A claim for a stress fracture of the foot from a letter carrier who walks a route, where the medical evidence confirms the diagnosis and relates it to extensive walking.

(c) A claim for carpal tunnel syndrome from a postal letter-sorting machine operator where medical tests establish the diagnosis.

(2) Extended OD -- Most other types of OD claims require full-scale development because the nature of exposure is in question, the diagnosis is

not clearly identified, or the relationship of the condition to the exposure is not obvious.

The following situations illustrate the kinds of cases which may be considered extended OD:

(a) Hearing loss due to continuous noise exposure.

(b) Asbestos-related illnesses.

(c) Stress-related conditions (cardiac, emotional, gastrointestinal).

(d) Other conditions, such as pulmonary conditions, gastrointestinal illnesses due to physical causes, certain types of loss of vision, dental conditions, cancers, nerve (neurological) injuries and tumors.

c. Death -- Death claims are discussed in FECA PM 2-0700.

d. Administrative Review (AR) -- an uncontroverted traumatic injury claim in which medical bills are not expected to exceed $1500 and a wage loss claim has not been filed. These cases are automatically closed upon case creation, without Claims Examiner (CE) review.

AR cases can be reopened automatically or manually. Such reopened cases will usually contain some medical evidence and may be adjudicated immediately. Extent and duration of injury-related disability do not have to be fully developed before adjudication. However, if one or more of the five basic requirements (timeliness, civil employee, fact of injury, performance of duty, causal relationship) is not met, the CE will proceed with development as with any other TI case. See 2-0800-4.

(1) Automatic Reopening. AR cases will be automatically reopened if the medical bills exceed $1500, a wage loss or recurrence claim is received, the “controverted indicator” in the case record is changed to "Y" due to receipt of a late agency controversion, or the COP nurse has closed the case without a return to full time employment by the claimant.

(2) Manual Reopening. AR cases may also be reopened manually. The case should be reopened when, for example, a request for surgery is received.

3. Forms Used for Initial Claims.

a. In injury cases, the appropriate forms are:

(1) Form CA-1, Federal Employee’s Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation.

(2) Form CA-2, Notice of Occupational Disease and Claim for Compensation.

(3) Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease, may be submitted in conjunction with the CA-1 or CA-2.

b. In death cases, the appropriate forms are:

(1) Form CA-5, Claim for Compensation by Widow, Widower, and/or Children.

(2) Form CA-5b, Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren.

(3) Form CA-6, Official Superior's Report of Employee's Death.

Death claims are discussed in FECA PM 2-0700.

c. Completion of Forms. It is essential that Form CA-1 or CA-2 be completed by both the claimant and the employing agency.

(1) Incomplete form. If enough information is provided on the CA-1 or CA-2 to permit creation of the case, OWCP should do so and obtain the missing information from the appropriate party.

However, if not enough information is provided on the CA-1 or CA-2 to allow creation of the claim (see FECA PM 1-0400), OWCP should return the form for completion.

(a) Employing Agency Known. When a CA-1 or CA-2 is received directly from the claimant, OWCP should send a copy to the employing agency with a request for completion of the reverse side of the form.

(b) Employing Agency Unknown. When a CA-1 or CA-2 is received directly from the claimant and the employing agency is not known or it cannot be determined from the information provided, OWCP should return the form to the claimant with instructions to forward the form to the employing agency for completion.

(2) Incorrect form. While submission of an incorrect form is a technical error, it is improper to deny a case on the basis that the claimant failed to submit the correct form. In some cases, the claimant may have been provided that form by the employing agency. Proper handling of the incorrect form depends on whether OWCP can determine the actual benefits claimed.

(a) If, upon review of the incorrect form, the actual benefits claimed by the claimant can be determined, OWCP should convert the

claim to the correct type and notify the claimant and employing agency (and any representative, if applicable) via letter that the claim has been converted to a different type of injury than what was originally claimed and explain the reasons for the conversion.

Example: The claimant files Form CA-2, Notice of Occupational Disease and Claim for Compensation, and OWCP creates an occupational disease claim. However, based upon the statements contained on the Notice of Occupational Disease as well as the medical evidence submitted, the claimant is describing a traumatic injury rather than an occupational disease claim. In such an instance, the Office can convert the claim from an occupational disease claim to a traumatic injury claim. The claimant and employing agency (and any representative, if applicable) should be notified via letter that the claim is now a traumatic injury, and the reasons for the conversion should be explained. If the claim was filed within 30 days of the injury date, the claimant should also be notified of the entitlement to Continuation of Pay (COP).

(b) If the actual benefits claimed by the claimant cannot be determined from review of the form, OWCP should develop the claim based upon the claim form filed and direct questions to the claimant to determine the type of benefits claimed. Based upon the response to the development letter, OWCP should make a determination as to whether the correct claim was established and, if not, OWCP should convert the claim to the proper type of claim and notify the claimant and employing agency (and any representative, if applicable) of the conversion.

Example: The claimant files a CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation, and OWCP creates a traumatic injury claim. However, upon review of the CA-1, the CE determines that the statements made on the claim form are so vague that it cannot be determined whether the claim is for a traumatic injury claim or occupational disease claim. The CE issues a development letter to the claimant requesting a statement on the nature of the injury. Based upon the response to the development letter, the CE determines that the claimant is not describing a traumatic injury but an occupational disease claim. OWCP will convert the claim to an occupational disease claim and notify the claimant and employing agency (and any representative, if applicable). In this particular circumstance, it is important that the CE also address the claimant's entitlement to COP.

4. Responsibilities.

a. Claimant. A person claiming compensation must submit sufficient evidence and demonstrate cause for OWCP to proceed with processing and adjudicating a claim. It is the claimant's responsibility to establish the five basic requirements of a claim, which is known as the "burden of proof." OWCP has the obligation to aid in this process by giving detailed instructions for developing the required evidence. The claimant must submit the essential evidence that demonstrates entitlement to compensation. The five basic requirements of a claim, which must be considered in the order given, are as follows:

(1) Statutory Time Requirements Have Been Satisfied. Compliance with this requirement is demonstrated when the notice of injury, disease, or death shows that prompt notice and claim were given and filed. The claimant has no particular responsibility unless the claim is not filed within three years after the injury. See FECA PM 2-0801.

(2) The Injured or Deceased Individual Was a Federal Civilian Employee or considered an employee for purposes of FECA. Compliance with this requirement is usually a routine matter which is demonstrated by inspection of the notice or claim. The claimant has the burden, however, when the employer is not an agency of the United States or the Federal agency denies the employment status of the injured or deceased. See FECA PM 2-0802.

(3) The Occurrence, or "Fact" of Injury (FOI). Once the first two elements are established, it must be determined whether an injury occurred. See FECA PM 2-0803. This element of the claim consists of two components, which must be considered together:

(a) Whether the claimant actually experienced the accident, untoward event, or employment factors alleged to have occurred. This is a factual determination. The claimant must show that the accident or work exposure that is claimed did in fact occur at the time and place and in the manner alleged.

In occupational disease cases in which the claim is not based upon a specific incident, the claimant must submit sufficient evidence to identify fully the particular work conditions alleged to have caused the disease and substantiate exposure to the conditions claimed.

(b) Whether a medical condition has been diagnosed in connection with this event or employment factor. To make this determination, medical evidence is required. However, there are a few instances when a claim may be accepted without a medical report. See paragraph 6 in this chapter.

(4) The Injury Occurred in the Performance of Duty (POD). The claimant must show not only that an injury occurred but that he or she was performing

official duties (or an activity incidental to employment) at the time of injury. The injury must arise out of and in the course of employment. See 5 U.S.C. 8102; FECA PM 2-0804.

(5) The Disability (or Death) Was Caused by the Injury Claimed (CR). The claimant must show that the injury was causally related to the event or employment factors. This requirement is satisfied on the basis of medical evidence, which is usually supplied by the attending physician. See FECA PM 2-0805.

b. Employing Agency. Although the employing agency is not formally a party to the claim, the agency bears a responsibility to assist in developing the claim. The FECA requires the employing agency to report to OWCP any injury resulting in death or probable work-related disability and to submit any further information requested by OWCP. 20 CFR 10.118. As evidence appearing in the employer's files is not generally available to claimants, the employing agency must assemble and submit such evidence.

(1) In addition to supplying evidence on its own behalf, the agency is expected, wherever possible, to aid the claimant in assembling and submitting evidence. In cases in which OWCP receives the claim long after the employee has left the agency's employment rolls, a claimant may need to assist OWCP in identifying any potential sources of evidence.

(2) Additional evidence from other sources may be needed where the agency's confirmation of the claimant's allegations is not sufficient to establish the claim, or where the official superior or injury compensation specialist disagrees with the claimant's allegations, has no knowledge of the facts concerning the allegations, or is unable to furnish sufficient details.

(3) Since OD claims generally require more detailed evidence, a supervisor or injury compensation specialist can, when issuing Form CA-2 to the claimant, also provide the claimant with a checklist showing the type of evidence which should be submitted. The checklists can be found in the CA-810 publication, Injury Compensation for Federal Employees, which is available on the Department of Labor’s website. Conditions covered include: hearing loss, asbestos-related illness, coronary/vascular disease, skin diseases, pulmonary conditions (other than asbestos), psychiatric conditions, and carpal tunnel syndrome.

c. OWCP. In administering the FECA, OWCP must attempt to obtain any evidence which is necessary for the adjudication of the case which is not received when the notice or claim is submitted. To adjudicate claims promptly and manage them effectively, the CE should choose the most efficient, direct, and proactive approach, given the individual circumstances of a claim and the nature of injury.

OWCP is responsible for the following:

(1) Providing Information. The CE must provide information about the procedures involved in establishing a claim, including instructions for developing the required evidence, to the claimant, the employing agency, and the representative, if any.

(2) Requesting Evidence. Upon initial examination of the case, if it is determined that the evidence is not sufficient to establish the essential elements of the claim (timeliness, civil employee, fact of injury, performance of duty, causal relationship), the CE should inform the claimant of the additional evidence needed. The CE should attempt to clarify any discrepancies which exist based on information already in the file at the time of development. The claimant will be allowed at least 30 days to submit the evidence required. OWCP is not required to notify the claimant a second time if the evidence submitted in response to its first request is not sufficient to meet the burden of proof. 20 CFR 10.121.

(3) Identifying Potential Third Party Cases. The CE should be alert for situations where a party other than another Federal employee or agency may be responsible for the injury (see FECA PM 2-1100). The claimant should be notified promptly of his or her obligation to pursue the responsible third party and to refund the government under 5 U.S.C. 8131 and 8132 so that attempts at recovery may begin before the applicable state statute of limitations expires.

(4) Making Prompt Decisions. It is OWCP's obligation to render a decision on each case as promptly as possible. Prompt action is particularly important in those disability cases where the injured employee is losing pay. The Office must notify both the claimant and the employing agency (and any representative, if applicable) of its decision in all cases, other than those that were administratively reviewed and have not reopened. If the case is accepted, OWCP should also respond to any agency challenges or controversions to COP.

5. General Development. This section provides general information for developing claims. The following sections will address the initial development of a claim for factual evidence and medical evidence. Claims that require extended development are discussed in paragraph 9 of this chapter.

a. Evidence. Decisions on claims are based on the written record, which may include forms, reports, letters, and other evidence of various types such as photographs, videotapes or drawings.

Evidence may not be incorporated by reference, nor may evidence from another claimant’s case file be used. Evidence contained in another of the claimant’s case files may be used, but a copy of that evidence should be placed into the case file being adjudicated. **All evidence that forms the basis of a decision must be in that claimant’s case record.**

b. Developing the Case. Development is usually undertaken in writing. Communication by fax may be used when an expeditious reply is required. A phone call can be made where the request involves answers to specific and simple questions, such as verifying that an inoculation resulting in an adverse reaction was performed by the employer. Evidence obtained by telephone must be carefully documented in writing (on Form CA-110) and depending on the complexity of the information obtained, written confirmation should be requested from the source. In developing a case, the CE should:

(1) Identify and request all information that will be required to adjudicate the claim for all conditions claimed.

(2) Acknowledge receipt of any Form CA-7 which has been submitted and indicate that the CA-7 will be reviewed when the case is adjudicated. This can be done in the development letter.

(3) Attempt to secure evidence in the custody of a Federal agency, as it is more readily available to OWCP than to the claimant. An example of this is exposure data of a historical nature such as in an asbestos case.

(4) Avoid requesting evidence which is already contained in the file or for which no need is anticipated. Such requests place an unwarranted burden on the individual or entity asked to submit the information and result in a duplication of documents in the case file.

(5) To the extent possible, the same CE should handle all claims involving the same part of the body for a given claimant. If another claim already exists for an injury to the same body part, the CE should generally double the case files. See FECA PM 2-0400.

c. Requesting Information. The CE should contact the claimant in writing to obtain information or clarification wherever possible. At times the CE may contact the claimant via telephone if only basic information is needed. This is discussed further in paragraph 7 of this chapter.

Correspondence Library has development letters which may be used when making initial requests for information from the claimant and the agency. When composing the letter, the CE should state what evidence is already in the case record and why it is not sufficient to make a decision. The CE should specifically request only the information necessary to adjudicate the case at hand. Any letter used should be tailored to the specifics of the individual case.

Where the claimant's statement is essential to understanding the basis of the claim (e.g., in emotional stress cases), the CE should wait until the claimant's statement has been received before sending the letter to the agency.

d. Lack of Response. The CE must allow at least 30 days for a response to all initial development letters prior to denying a claim. 20 CFR 10.121. If information is

requested of the employing agency, a reasonable period of time should be allowed for the agency's response.

(1) If an employing agency fails to respond to a request for comments on the claimant's allegations, the CE may usually accept the claimant's statements as factual. However, acceptance of the claimant's statements as factual is not automatic in the absence of a reply from the agency, especially in instances where performance of duty is questionable. The Employees' Compensation Appeals Board has consistently held that allegations unsupported by probative evidence are not established. James E. Norris, 52 ECAB 93 (1999), Michael Ewanichak, 48 ECAB 354 (1997). The CE should consider the totality of the evidence and evaluate any inconsistencies prior to making a determination.

(2) If the claimant fails to respond, the CE will need to decide whether to adjudicate the claim without the requested information. Often the CE can continue to develop a claim and reach conclusions on the five basic requirements even when some evidence is lacking.

For example, if the CE asks the claimant to submit medical records for a prior hospitalization or operation, but the claimant does not do so, the CE may still be able to adjudicate the case without them. While records of past medical treatment are helpful, their absence may not necessarily prohibit further development of the claim or a decision on causal relationship. If the missing records are essential, the claim may be denied and the decision should explain why causal relationship cannot be accepted without the missing medical records.

6. No Development Necessary - Visible Injury. When the following criteria are satisfied, a case may be accepted without a medical report and no development of the case need be undertaken:

a. The condition reported is a minor one which can be identified on visual inspection by a lay person (e.g., burn, laceration, insect sting or animal bite);

b. The injury was witnessed or reported promptly, and no dispute exists as to the occurrence of an injury; and

c. No time was lost from work due to disability.

In cases where there is a serious injury (motor vehicle accidents, stabbings, shootings, etc.), the agency does not dispute the facts of the case, and there are no questionable circumstances, the case may be accepted for a minor condition (such as a laceration in a stabbing case) without a medical report, while simultaneously developing the case for other more serious conditions. This is true even if there is lost time due to such a serious injury. In these cases, once a Field Nurse is assigned (see FECA PM 2-0811), he or she can assist with obtaining the necessary evidence. Sound judgment should be employed in these serious cases to provide appropriate and immediate medical care for the injured worker

since expeditious treatment for these injuries is critical.

7. Development of Factual Evidence. The purpose of this paragraph is to identify the kinds of factual evidence needed in traumatic injury and occupational illness cases, and how to obtain this evidence. Before making any inquiries, the CE should carefully review all material in the case record, both to identify evidence needed for adjudication and to avoid requesting evidence already provided or not needed.

a. Sources of Factual Evidence. The type of evidence necessary to adjudicate a claim will determine how the CE obtains the evidence and from whom he or she will request information.

(1) Claimant. In disability cases, the claimant is the injured employee, while in death cases the claimant is the dependent seeking benefits. Whenever there is a factual discrepancy in a case, the claimant should be contacted to clarify the facts of the case. Depending on the facts of the case, it may be necessary to forward the claimant's statement to the employing agency for comment.

(2) Employing Agency. The employing agency is required to complete the reports and statements needed and then submit the evidence to the OWCP. In several types of claims (e.g. stress claims, claims with POD issues such as premises, temporary duty travel, or recreational injuries), a statement from the employing agency is imperative to properly develop and adjudicate the claim.

(3) Witnesses. Statements from witnesses are not required to adjudicate a claim; a claim may be approved in the absence of witness statements. They are very useful, however, when the employing agency is unable to confirm or refute the claimant's allegations. Such statements may be obtained by the claimant or the employing agency.

(4) Other Sources. In most cases, the required evidence will be available from one of the sources noted above. In certain cases, however, the CE will need to request evidence from other sources. This will vary by case and circumstance.

b. Factual Discrepancies.

(1) Nature of Claim. If doubt exists, the claimant should be asked to clarify what condition is being claimed, or whether the claimed condition is due to an occupational disease, a traumatic injury, or a recurrence. Any discrepancies found must be clarified by obtaining the necessary factual evidence before the claim can be properly adjudicated.

(2) Description of Job Duties. This will almost always be required to adjudicate an occupational disease claim, and occasionally will be required for a traumatic injury, especially if it is not clear what the claimant's occupation entails.

(a) The employing agency should be asked to provide a position description, including physical requirements, and clarification of job duties.

(b) The claimant should usually be asked to describe the physical and environmental requirements of the job, and the supervisor or injury compensation specialist should review that statement and provide comments if there is any disagreement.

(c) Where the position description accurately describes the factors claimed as the basis of a medical condition in a claim for occupational disease, it is not always necessary to request a detailed statement from the claimant describing these factors. For example: where aggravation of degenerative disc disease due to repeated heavy lifting is claimed, and the position description states that frequent lifting over 50 pounds is required, it can be accepted that the claimant often lifted heavy objects. If an employee claims a reaction to breathing paint fumes, and the position description states that he or she works with paint in poorly ventilated areas, this can usually be accepted as factual.

(3) Employment History. This information is primarily required for occupational disease claims. The employing agency is often the best source for a chronological history of employment because of the recordkeeping involved in a personnel office. The claimant should also be asked to submit this information, especially for jobs held prior to employment with the employment agency.

(4) Exposure to and Identification of Substances. The employing agency is usually the best source for this data. However, if the agent to which the claimant was exposed was clearly encountered in the work place, it is preferable but not always necessary to identify the specific agent. For example, if the case involves a respiratory condition clearly related to exposure to fumes at work, or dermatitis from contact with a cleaning solvent used at work, the agent need not necessarily be specified.

(5) Content of Substances. If the employing agency is unable to identify the contents of the substance, the manufacturer will likely be the best source for obtaining that information. If such exposure is claimed, the CE should consider whether potential third-party liability exists. If so, the case must be processed according to FECA PM 2-1100.

(6) Personal History. The claimant is the best source for information concerning off-the-job exposure to potentially injurious conditions or substances. However, medical reports containing history elicited by physicians who have examined the claimant sometimes include useful factual information. For example, personal or family history may appear in a claim for a psychiatric or heart condition. The CE should ask the claimant to verify

any facts obtained from a medical report.

(7) Various Performance of Duty (POD) Scenarios. In traumatic injury claims, a variety of POD issues may present themselves. These include injuries sustained off premises; injuries sustained while the employee is on TDY status; recreational injuries; and injuries sustained in parking lots/garages. In these instances, the CE should obtain a statement directly from the claimant identifying the circumstances surrounding the injury. The CE should also obtain a statement from the employing agency concerning whether the injury was sustained in the performance of duty. See PM 2-0804 for a complete discussion of POD.

(8) Affirmative Defense. The FECA states than an injury caused by the claimant's intoxication, willful misconduct, or intent to injure self or another is not compensable. These factors are described and their development discussed in FECA PM 2-0804, Performance of Duty. The claimant enjoys an affirmative defense against any finding that one of these factors applies to a claim, and OWCP must overcome such a defense. These factors must be considered and developed prior to the initial adjudication of the claim, since an affirmative defense cannot be raised for the first time on appeal. Adverse decisions of this type should be made at an adjudicative level above that of the CE. See FECA PM 2-0804.

c. Obtaining Information by Telephone. Use of the telephone is encouraged to obtain information when appropriate. If the claimant has difficulty with written communication, the CE should contact the claimant by telephone. In other instances, especially if the CE lacks just one or two pieces of information to take an action, it may be expedient to contact the claimant by phone and document the case file. The CE should complete a comprehensive and informative Form CA-110 for the case record as soon as possible.

However, where there are disputes in the factual evidence, the case should be considered for conferencing.

d. Conferencing. The CE may use conferencing as a method to obtain necessary data or to clarify significant disputes or discrepancies in the case record prior to adjudication. Procedures for conferencing are fully described in FECA PM 2-0500. The CE should consider conferencing in situations where:

(1) Conflicting evidence exists on an issue important to the adjudication of the case, and the CE has not been able to resolve the issue.

(2) The employing agency has challenged the claim on the issue of fact of injury or performance of duty.

(3) The evidence clearly shows the claimant cannot communicate effectively in writing.

(4) The agency challenges the claimant's allegations and provides conflicting factual evidence.

(5) The agency has not responded to a written request, or its response requires clarification.

e. Phrasing Questions. The way a question is asked can affect the amount and quality of information which will be received. Broadly speaking, development questions can be asked in three ways:

(1) Open Questions. These are phrased so that minimal information is presented in the question and allows the respondent to provide all the specific details about the particular issue at hand.

Example 1: How were you harassed on February 3, 2011? What happened that day? Provide details including names and titles of any witnesses or participants as well as what they said and what occurred.

Example 2: You indicated that you suffered an injury at work on February 4, 2011. How did the injury occur? What type of injury did you sustain?

(2) Direct Questions. These require either yes/no answers or very short responses.

Example: You indicated on Form CA-1 that you tripped while delivering the mail, injuring your foot. What part of the foot did you injure? Describe precisely how you injured your foot - Did you twist it? Turn it? Did you get an x-ray of your foot following the injury?

(3) Leading Questions. These are phrased to suggest what the answer should be.

Example: Your supervisor indicates that you were not scheduled to work on February 7, 2011 and therefore counseling did not occur on this date. Is this correct?

Although leading questions can be helpful when trying to solicit specific factual information from the claimant or employing agency, particularly if the respondent if unwilling or unable to respond to open or direct questions, they should be used only as a last resort.

Note - Leading questions may never be used in the context of a referral to an impartial medical specialist.

(4) Combined Questions. Open questions are best used when little information about a given matter is available. The drawback to this type of question is that while a great deal of information may be received, it may not adequately address the issue if the question is not specific enough.

Therefore, it is best to follow an open question with a direct question, since it requires more specificity.

8. Development of Medical Evidence. The purpose of this paragraph is to identify the kind of medical evidence needed in traumatic injury and occupational illness cases, and how to obtain this evidence. Before making any inquiries, the CE should carefully review all material in the case record, both to identify evidence needed for adjudication and to avoid requesting evidence already provided or not needed.

a. Medical Sources. These sources include reports of physicians and hospitals providing examination or treatment to the claimant either before or after the injury. The claimant is responsible for obtaining the necessary medical evidence; however, the CE may also obtain medical evidence from a physician who examined the claimant through direct referral or authorization by OWCP (for example, a second opinion medical referral).

The CE should direct the employing agency to submit all medical documentation related to the claim which is in its possession, including documentation of any treatment the claimant received at the employing agency's medical facility or health unit.

Medical records may also be requested directly from the claimant or the attending physician. If necessary, the CE should send the claimant an authorization for release of records (Form CA-57) to sign and return. The CE may also authorize diagnostic tests for the part of the body that has been injured if he or she determines the results of such testing would be useful.

b. Initial Review and Development of Medical Evidence.

(1) Upon initial review of a new claim for injury, the CE should evaluate any medical evidence which has been received in the case record. For most conditions, the attending physician's opinion may be considered conclusive for adjudicating the claim if he or she is a specialist in the indicated field of medicine; has a complete and accurate history of the employment factors; and provides sufficiently detailed information, including the medical reasoning required to determine diagnosis and causal relationship.

There are some circumstances in which medical evidence is not required to adjudicate a claim or where a rationalized medical opinion is not required. This is addressed in FECA PM 2-0805. See also the discussion of Visible Injuries in paragraph 6 of this chapter.

(2) If after initial review, the medical evidence is not sufficient to accept the claim (or no medical evidence has been received), the CE should request the medical evidence necessary to support the claim. The request should be tailored to the specifics of the case, but should note that the medical evidence must be obtained from a physician, as defined by the FECA. The letter must also inform the claimant that he or she has 30 days to submit the requested

evidence. In general, medical reports must provide a history of injury or work factors; a diagnosis; objective findings supporting the diagnosis; and a rationalized medical opinion on the issue of causal relationship.

In most cases, the CE should request that the claimant obtain the medical evidence from the physician as part of the initial development letter. If the CE writes directly to the attending physician to obtain this information, the letter should contain a clause addressed to the claimant which clearly informs him or her that although the letter is written directly to the physician, it is still the claimant's responsibility to ensure that the requested information is provided within the time allotted.

(3) Following the issuance of the initial development letter, the CE should review any new medical evidence submitted. If no medical evidence has been submitted or the medical documentation does not contain *prima facie* medical evidence (see paragraph below), the claim may be adjudicated based on the evidence of record without further development. The CE should ensure that all medical evidence in the case record is considered at the time of adjudication and that the claimant has been provided at least 30 days to submit the medical evidence requested.

For OWCP to undertake additional medical development, the claimant must establish a *prima facie* case by submitting medical evidence from a physician which, at the least, states a diagnosis and clearly supports causal relationship. However, in some cases, the medical opinion need not be fully rationalized in order for the CE to undertake further development. For example, the attending physician may provide a diagnosis and an opinion which is not well-reasoned but nonetheless supports causal relationship. In such cases, further clarification is needed to establish the case, and the medical development should be undertaken by the CE.

c. Request for Additional Medical Evidence. If further development of the medical evidence is required, the CE must undertake such development prior to rendering a decision. Further medical opinion may be requested from attending physicians, second opinion specialists, and referee specialists. The roles of these physicians and the weighing of medical evidence are addressed in FECA PM 2-0810.

(1) Requests to the Attending Physician. Unless the medical history of the case demonstrates that an inquiry to the attending physician will not be productive, it is usually proper to write to the attending physician at least once to obtain the missing information before arranging a second opinion referral. The attending physician should be given the opportunity to bill OWCP for a comprehensive report.

The CE should send the claimant a copy of this and all other letters to the attending physician and advise the claimant that even though OWCP is attempting to obtain the evidence needed to adjudicate the claim, it remains the claimant's responsibility to ensure that the required evidence is

submitted.

When sending the letter to the Attending Physician, the CE must be sure to:

(a) Provide a factual background and pose specific questions;

(b) Advise the physician that OWCP will pay for a comprehensive report;

(c) Notify the claimant that the requested medical opinion is necessary to further develop the claim; and

(d) Advise the claimant that he or she is responsible for ensuring that the physician submits the report within the time allotted.

(2) If the CE determines that questioning the attending physician further would not be productive, a referral to a second opinion specialist may be warranted. If there is a conflict in the medical evidence between the attending physician and the second opinion specialist and the evidence is of equal but opposing value, a referral to a referee physician may be needed. The procedures for referring cases to second opinion and referee specialists are addressed in FECA PM 3-0400.

(3) Statement of Accepted Facts (SOAF). A SOAF is often necessary when requesting such medical evidence from the attending physician and required when referring the claimant to a second opinion or referee in this circumstance. Refer to FECA PM 2-0809 for instructions on preparation of a SOAF.

(4) Questions to Physicians. Questions to a physician should address all unresolved medical issues. The CE should not request medical evidence from the physician which he or she has provided already. When preparing questions for a physician, the CE should:

(a) Include questions about the history of injury, diagnosis, examination or diagnostic findings, causal relationship (with medical reasoning), and nature and extent of injury-related disability for regular and light duty.

With respect to the issue of causal relationship, it may be useful to provide the physician with OWCP's definitions of direct causation, aggravation, etc. See FECA PM 2-0805.

(b) Clarify a potential aggravation. If there is a question of whether the diagnosis was a pre-existing condition which was aggravated by the work injury/factors, the CE should ask the physician to clarify this.

Example: "You have opined that the claimant's right knee arthritis is related to the duties of handling luggage as a baggage screener over the last two years. Please clarify whether the right knee arthritis was directly caused by the work factors identified or if this diagnosis was a pre-existing condition which was aggravated by the work factors claimed."

The physician should also be asked to clarify whether an aggravation of a pre-existing condition is permanent or temporary, and if only temporary, when the condition is expected to return to baseline (pre-injury) status.

With respect to injury-related disability, the CE should be particularly careful to clarify its extent and duration in cases involving aggravation of an underlying condition.

(5) Phrasing Questions. The way a question is asked can affect the amount and quality of information which will be received. Questions can be asked in three ways: Open Questions, Direct Questions and Leading Questions. These types of questions are defined in paragraph 7(e) above and examples of each follow.

(a) Open Question Examples: What is the history of injury as provided by the claimant? What is the diagnosis? What are the objective exam findings/diagnostic findings? Please provide a well-explained opinion on whether the condition was caused or aggravated by the work injury on 04/10/2010.

(b) Direct Question Example: You have opined that the claimant's pre-existing right knee arthritis was aggravated by the work injury on 04/20/2010. Please explain whether this is a permanent aggravation or a temporary aggravation. If temporary, when did the aggravation cease, or when do you expect the aggravation to resolve?

(c) Leading Question Example: Given that the claimant has only been on the job carrying mail for three days, isn't it more likely that his condition of plantar fibrosis is the result of non-work related factors?

Note - The CE should avoid leading questions when requesting evidence from a physician, especially if the question is phrased in such a way as to elicit a response which would invalidate the claim, and leading questions may **never** be used in the context of a referral to an impartial medical specialist. Stanislaw M. Lech, 35 ECAB 857 (1984) (ECAB found "Give date when aggravated disability ceased" to be leading).

(d) Combined Questions Example: You have indicated that the

claimant tripped over a log and has “abnormal findings about the right ankle.” What is the diagnosis? What are the “abnormal” exam findings/diagnostic findings? Was the diagnosed condition caused by the trip and fall? Please provide medical reasoning in support of your opinion.

d. Lack of Response. When a CE requests an opinion from the attending physician but receives no reply within a specified period of time, the claim may be adjudicated based on the evidence on file without further development if the CE has:

(1) Provided a factual background and posed specific questions to the attending physician;

(2) Advised the physician that OWCP will pay for a comprehensive report;

(3) Notified the claimant that the requested medical opinion is necessary to further develop the claim; and

(4) Advised the claimant that he or she is responsible for ensuring that the physician submits the report within the time allotted.

e. Medical inquires by telephone. The telephone may be used to schedule examinations, request reports, and address other administrative matters. However, long-standing ECAB precedent provides that oral statements of doctors to OWCP personnel do not constitute competent medical evidence (see John M. Fuller, 9 ECAB 320).

In addition, OWCP examiners may not communicate orally with a referee medical specialist with regard to the examination details or information contained within the report. Such communication must be made in writing. See FECA PM 3-0500. OWCP may communicate with a referee specialist’s office for administrative matters such as scheduling an examination or requesting a report.

As with any other telephone call requiring documentation, OWCP personnel should complete a comprehensive and informative Form CA-110 for the case record.

9. Extended Development. Some initial claims require full-scale medical development because the nature of exposure is in question, the diagnosis is not clearly identified, or the relationship of the condition to the exposure is not obvious.

a. Requirements for development and documentation of certain types of conditions.

(1) Hearing loss and asbestosis claims. OWCP should refer the claimant for examination by a qualified specialist if the report submitted by the claimant does not meet all of OWCP's requirements for adjudication (see FECA PM 3-0600).

(2) Cardiac and psychiatric conditions. If the medical evidence submitted by the claimant clearly addresses the necessary requirements and the physician is of the appropriate specialty, the CE should prepare a memo to file stating where in the medical reports of record the questions have been answered. After completing the memo, the CE may adjudicate the claim.

If the report submitted by the claimant does not meet all of OWCP's requirements for adjudication but establishes a *prima facie* case, the CE should prepare a detailed SOAF and questions for the physician. The CE then can write directly to the attending physician (if of the appropriate specialty) as outlined in paragraph 8(c) of this chapter or refer the claimant for examination by a qualified specialist.

10. Obtaining Evidence from Employing Agencies. OWCP will attempt to obtain evidence in possession of another Federal agency. Following is a description of the procedures which should be used with respect to requests for information from employing agencies.

a. Factual Evidence. If the agency has factual evidence which is necessary to make a decision in the claim, the CE should make a written request with a copy to the claimant, indicating a time period within which the agency should reply. The agency should be advised that if it fails to provide the requested information, a decision will be made on the basis of available evidence and that the claimant's statements, if sufficiently clear and detailed, may be accepted on matters of which the claimant is knowledgeable.

b. Medical Evidence. If it appears that the agency has medical records in its possession pertaining to the injury or to any relevant pre-existing condition, the CE should ask the agency to submit copies of such records if they are not sent with the original submission.

c. Transferred Employees. When a Federal employee transfers from one agency to another, the employee's Official Personnel Folder (OPF) and Employee Medical Folder (EMF) should be sent to the new agency. If the OWCP requires information from the OPF or EMF after the employee has transferred from the agency where the injury occurred, the original employing agency may be unable to supply it. The CE should request the information from the current employing agency.

11. Withdrawal of Claim. A claimant or survivor may submit a written request to withdraw his or her claim prior to the adjudication of the claim. This includes claims for traumatic injury, occupational disease, and survivor benefits. It also applies to administrative review cases that have not been formally adjudicated. Although a claimant or survivor may withdraw a claim, the notice of injury itself cannot be withdrawn. [See FECA Regulations, 20 C.F.R. 10.100(b)(3), 10.101(a), and 10.105(a)].

a. Upon receipt of a written request from the claimant or survivor, the CE must take the following actions:

(1) In any compensation case where a written notice of intent to withdraw

a claim is received from the claimant or survivor prior to the adjudication of the claim, the CE must advise the claimant or survivor in writing that the claim is now considered withdrawn.

(2) The case file will then be coded as withdrawn and the imaged copy retained by the Office. The CE should code the claim as follows:

Adjudication Status: SU
Case Status: CL

(3) No ICD-9 code can (or should) be entered.

(4) In traumatic injury cases, determine if COP was paid. Any COP that was paid will be charged to either sick or annual leave or become an overpayment with the employing agency.

b. Employing agencies are not permitted to compel any employee or survivor to withdraw a claim. Upon notification of a credible allegation that the employing agency improperly compelled the claimant or survivor to withdraw a claim, the District Director or other designated individual, should immediately contact the employing agency by telephone or written correspondence to discuss the matter and to prevent any future occurrences. The telephone conversation must be documented on Form CA-110 and the form imaged in the case record.

c. A claim may be reinstated if there is evidence that a claimant or survivor may have been compelled by the employing agency to withdraw his or her claim. If the claim is reinstated, the claimant or survivor should be notified in writing that the claim is now considered reinstated.

d. If a request is received to reopen a withdrawn claim, a new case number should be assigned. The CE should use the information from the previously withdrawn claim to develop any issues (e.g., performance of duty) in the new case.

12. Group Injuries. When possible, where two or more employees are injured in the same incident, such as an explosion or auto accident, or by the same substance, such as contaminated drinking water, the entire group of cases should be adjudicated by the same CE in order to ensure uniformity of action.

Exhibit 1: Nature of Injury Codes

(T) Traumatic Injuries

TA	Amputation
TB	Back strain
TC	Contusion; bruise; abrasion
TD	Dislocation
TE	Exposure (including frostbite, heat stroke/exhaustion)
TF	Fracture
TG	Effects of Electrical Current
TH	Hernia (inguinal)
TJ	Crush injury
TK	Concussion
TL	Laceration; cut
TN	Superficial Wounds
TO	Pain, Swelling, Redness, Stiffness (not in joint)
TP	Puncture (not insect bite)
TS	Strain (not back)
TT	Tooth injury
TU	Burn, scald, sunburn
TV	Foreign body in eye
TY	Insect bite
TI	Traumatic skin diseases/conditions, including dermatitis
TR	Traumatic respiratory disease
TQ	Traumatic food poisoning
TW	Traumatic tuberculosis
TX	Traumatic virological/infective/parasitic diseases
TY	Insect Bite
TZ	Pain, Swelling, Redness, Stiffness (in joint)
T1	Traumatic cerebral vascular condition; stroke
T2	Traumatic hearing loss
T3	Traumatic heart condition
T4	Traumatic mental disorder; stress; nervous condition
T5	Headaches
T6	Death sudden/Violent
T7	General Symptoms
T8	Traumatic injury - unclass. (except disease, illness)

(G) Gastrointestinal

GD	Diarrhea
GH	Hiatal, umbilical or ventral hernia
GO	Hernia, Other
GP	Abdominal Pain
GU	Ulcer
G9	Gastrointestinal, not otherwise classified
TQ	Gastrointestinal Conditions

(S) Skin Disease or Condition

SB Biological (including poison ivy, poison oak)
SC Chemical
SL Skin lesion (including blister, bunion, callus and corn)
S9 Dermatitis, not otherwise classified

(M) Musculoskeletal and Connective Tissue

MA Arthritis
MB Back or neck strain, sprain
MC Carpal Tunnel Syndrome
MD Degenerative Disc Disease; spondylosis; spondylitis
MI Inflammatory Disease (including bursitis, tendinitis)
MK Chondromalacia
MP Pain/Swelling/Stiffness/Redness (in Joint)
MS Pain/Swelling/Stiffness/Redness (not in Joint)
M9 Musculoskeletal condition, not otherwise classified

(R) Respiratory Disease

RA Asbestosis
RB Bronchitis, asthma
RC Asthma
RE Emphysema
RP Pneumoconiosis (Black Lung)
RR Reaction to smoke, fumes, chemicals
RS Silicosis
R9 Respiratory disease, not otherwise classified
TR Respiratory Conditons

(V) Virological, Infective and Parasitic Diseases

VA Acquired Immune Deficiency Syndrome (AIDS) and HIV
VB Brucellosis
VC Valley Fever (Coccidioidomycosis)
VD Anthrax
VF Rabies
VH Hepatitis
VL Lyme Disease
VM Malaria
VP Parasitic Diseases
VR Rocky Mountain Spotted Fever
VS Staphylococcus
VT Tuberculosis

V9 Virological/Infective/Parasitic, not otherwise classified

(C) Cardiovascular/Circulatory

CA Angina
CB Blood Disorder
CH Hypertension
CM Myocardial Infarction (Heart Attack)
CP Phlebitis; varicose veins
CS Stroke; cerebral vascular condition
C9 Cardiovascular/circulatory, not otherwise classified

(O) Occupational disease, non-complex

OF Food poisoning
OG Tooth and gum-related problems
OL Inguinal Hernia
OP Pregnancy (Peace Corps only)

(D) Other Disability, Occupational

DA Headaches
DB Seizures/Convulsions
DC Coma
DF General Symptoms: Syncope, Dizziness, Vertigo, Fatigue
DH Hearing loss
DI Vision/sight loss
DM Mental disorder; emotional condition; nervous condition
DN Nerve injury, incl. paralysis, after exposure to toxins
DR Radiation
DT Tumors and other cancer-related conditions

2-0801 TIME

TABLE OF CONTENTS

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

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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

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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

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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.

17. Work-Connected Events Which Are Not Factors of Employment.

a. The Cutler Rule. As the ECAB stated in the case of Lillian Cutler, 28 ECAB 125:

> Workers' compensation law does not apply to each and every illness that is somehow related to an employee's employment... Where the disability results from his emotional reaction to his regular or specially assigned work duties or to a requirement imposed by the employment, the disability comes within the coverage of the Act.

This concept has come to be known as the Cutler rule.

When an employee experiences emotional stress in carrying out assigned employment duties, or has fear and anxiety regarding his or her ability to carry out these duties, a resulting disability is considered to have "arisen out of and in the course of employment." Similarly covered is a disability arising from a special assignment or requirement imposed by the employing establishment. The assignment need not have been unusually strenuous, as long as the medical evidence shows that it caused the claimed condition. The Board continues:

> On the other hand, the disability is not covered where it results from such frustration from not being permitted to work in a particular environment or to hold a particular position.

In Cutler, where the employee became emotionally upset over not receiving an anticipated promotion, the Board held that:

> the resulting disability does not have such a relationship to the employee's assigned duties as to be regarded as arising from the employment. The emotional reaction in such circumstances can be truly described as self-generated and as not arising out of and in the course of employment.

"Self-generated" in this context apparently refers to the employee's voluntary application for a higher position, when to seek promotion was not a requirement of the position she already held.

b. Reassignment. The Board has applied the Cutler standard in other cases largely by example, always seeming to distinguish between the performance (or the results) of actual work duties, and dissatisfaction with the structure of the work or position. Thus, under the standard set forth in Cutler, it is clear that reassignment is not a factor of employment: Dario G. Gonzales, 33 ECAB 119; Clair Stokes, Docket No. 82-508, issued May 24, 1982; John A. Snowberger, Docket No. 85-2076, issued January 31, 1986; Robert C. McKenzie, Docket No. 85-532, issued May 10, 1985; Teresa M. Lacona, Docket No. 88-1262, issued May 8, 1989.

However, the case of Brenda Getz, 39 ECAB 245, presents a different situation. Here the employee alleged that she had an emotional reaction to a detail assignment to another city because of the working conditions involved. The Board concluded that the detail assignment constituted specially assigned work duty within the meaning of Cutler and therefore any disability arising out of an emotional reaction to the assignment would be covered.

c. Performance Ratings. The Board remanded the case of Lizzie J. McCray, 36 ECAB 419 listing the dispute over the employee's performance rating as a factor of employment and citing Derderian. But in Arthur F. Hougens, 42 ECAB 455, the Board found that the employee's reaction to his rating on his performance evaluation was not covered under the Act. The Board stated:

> In view of the fact that appellant's rating was "satisfactory" and was changed to a higher rating on his appeal, his reaction to it can accurately be described as "self-generated." Appellant has presented no evidence to substantiate his contention that a rating of satisfactory was a "bad rating" and "as low as you can go" at his employing establishment.

Although the Board did not state the distinction between Hougens and Derderian and McCray, the Board finding that Hougens' reaction was self-generated apparently is based on the fact that his performance was evaluated as satisfactory and his mere perception of the rating as a "bad" one was not sufficient for his reaction to be covered under the Act.

This interpretation is reinforced by the Board's decision in Thomas D. McEuen, 41 ECAB 387 and 42 ECAB 566. In McEuen the Board stated:

> In this case, the medical evidence establishes more than appellant's feeling of job insecurity: It establishes that appellant's episode of severe depression and impaired functioning was directly precipitated by what appellant regarded as an unsatisfactory performance appraisal. The Board finds that appellant's emotional reaction bears a direct relationship to his regular or specially assigned duties and constitutes an injury in the performance of duty within the meaning of the Act.

The Office petitioned for reconsideration on the ground that the Board's January 10, 1990 decision contained legal and factual errors. The petition stated in part:

> In the decision on January 10, 1990, the Board concluded that appellant's depression constituted an emotional condition sustained while in the performance of duty because it was "directly precipitated by what appellant regarded as an unsatisfactory performance appraisal." In so doing, the Board departed from longstanding precedent holding that feelings of job insecurity do not constitute an illness sustained while in the performance of duty. Raymond S. Cordova, 32 ECAB 1005 (1981); Lillian Cutler, 28 ECAB 125 (1976). Rather, the Board concluded that "feelings of job insecurity" may be compensable, depending upon the "source" of those feelings.

In an April 3, 1991 decision granting petition for reconsideration and reaffirming its January 10, 1990 decision, the Board noted:

> an unsatisfactory performance rating, without more, is insufficient to provide coverage. Although the rating is generally related to the employment, it is an administrative function of the employer, not a duty of the employee. As was held in Cutler, an emotional reaction under such circumstances would be self-generated. Exceptions will occur, however, in those cases where the evidence discloses error or abuse on the part of the employing establishment. That is what has occurred in this case. An error was committed by the employing establishment that resulted in appellant's emotional reaction. Such a reaction cannot be labeled "self-generated."

In the instant case, appellant felt the employer was out to get his job. He based this "perception" on the fact that, instead of receiving a performance rating when due, the employer deferred it in several particulars for 90 days. He alleged, and the employer conceded, that the proposed performance rating was incorrectly based on standards not derived from his job description and, with these standards removed, his performance was satisfactory. As the Office correctly points out, appellant was never given an 'unsatisfactory' rating. The rating was simply deferred for 90 days. The decision here therefore turns, not on whether the performance rating was unsatisfactory per se, but on the fact the employer took erroneous action that resulted in the employee's emotional condition. Such reaction cannot be deemed self-generated.

The Board has thus made it clear that an unsatisfactory performance ratings, performance assessments and informal discussions of performance, standing alone, are insufficient to provide coverage under the Act. An employee's reaction to an unsatisfactory performance rating, performance assessment or informal discussion of performance, absent any evidence of error or abuse by the employing establishment, is self-generated and therefore not compensable.

d. Fear of Removal. The Board has also distinguished between an employee's reaction to criticism arising from performance of day-to-day duties, or fear of inability to perform, and the fear of losing a job or a particular position, even when a performance evaluation is the sole or principal reason for an employee's actual or possible removal or job change.

In Allen C. Godfrey, 37 ECAB 334, the employee alleged extreme depression due partly to his reaction to a letter received from the employing establishment proposing to remove him from his position for failure to meet certain performance requirements of his job. His performance deficiencies were documented in official performance evaluations. A subsequent letter from an agency official stated he would not sustain the proposal to remove the employee but would assign him to a lower-graded position.

The Board referred to two of its previous decisions where an employee's reaction to a

discussion with his supervisor concerning the performance of his work duties, and another employee's emotional reaction to attempting to meet quality and quantity standards for his job, both constituted injury in the performance of duty. In this case, the Board found the facts to lead to the contrary conclusion that, while the employee's disabling reaction had some connection to his employment, it was not a reaction to his day-to-day duties or fear or anxiety concerning his ability to perform his employment duties but to what he perceived as a "sudden loss of his career." The employee's disabling emotional reaction was due to a fear of losing his job and a fear of losing a particular position, which does not constitute a factor of employment.

e. Harassment. Since Stanley Smith, 29 ECAB 652, the Board has consistently held that an employee is not required to show that a supervisor's actions constituted harassment or were improper as long as the employee could show that the disability arose directly from experience of the supervisor's actions and reaction to them, and that the actions themselves were appropriately related to the employee's assigned duties and position. In Lewis Leo Harms, 33 ECAB 897 (902), the Board stated:

> Where an employee asserts that emotionally stressful employment situations or conditions, including actions by the employing establishment described by the employee as constituting harassment or discrimination, caused a disabling condition on his part, the issue, generally speaking is not whether in fact there was harassment or discrimination but instead is whether such disabling reaction was precipitated or aggravated by conditions of employment. The Board's function is not to make a finding on the merits of an employee's charges against the employing establishment; its only function is to determine whether or not the medical evidence supports causal relationship between the employment factors alleged and the physical conditions.

Thus, the Board makes no determination of whether harassment occurred and does not require the Office to make factual determinations of whether an employee was the victim of harassment or discrimination. The Board does, however, rely on the findings of agencies or bodies which have the authority, and whose function it is, to decide the validity of an employee's allegations.

In the case of Norman A. Harris, 42 ECAB 923, the employee alleged that he sustained an emotional condition causally related to his federal employment. The employee was terminated by his employing establishment for falsifying his time records. He appealed the termination to the Merit Systems Protection Board (MSPB) and was restored to his position. The MSPB found:

> There was no showing that the appellant intentionally misrepresented his hours or deceived the agency by claiming hours that he did not work.... The charges in this case are predicated upon the appellant reporting late on various dates during the period in question. However, I note that the agency presented no evidence from Paramount officials who could verify [whether or not appellant was] at work.

The MSPB reversed the removal action. Based on the MSPB decision the Board found that the employing establishment had terminated the employee without the proper evidence and that this error was sufficient to bring any emotional reaction by the employee to the termination action within the coverage of the Act. The Office was directed to determine whether the employee had established that he sustained an emotional condition causally related to the termination action.

f. Erroneous Administrative Actions. In Robert E. Green, 37 ECAB 145, the employee alleged an emotional condition stemming from charges that he had falsified lodging costs on his travel vouchers and a finding that he had to reimburse the Government $24,423.14. He was removed from his position for falsifying official records for monetary gain and for other unrelated charges. The MSPB found no evidence of willful intent to defraud the agency by submitting false travel vouchers and no evidence that the lodging expenses submitted were false, but sustained the employee's removal on the other charges. Citing 5 U.S.C. 5702, which provides a per diem allowance for Federal government employees traveling on official business away from a designated post of duty, the Board found that the employee's emotional reaction to the denial of the reimbursement of his travel expenses constituted an injury sustained in the performance of duty. The circumstances relating to the travel vouchers were part of the employment and related to the duties the employee was employed to perform. Since the employee had been exonerated of charges that he falsified official records, there was no wrongful misconduct charge which would prevent coverage of his alleged emotional condition under the Act.

In Mary Alice Cannon, claiming as widow of Aubrey B. Cannon, 33 ECAB 1235, the employee received an erroneous personnel action reducing his salary. He suffered cardiac arrest and subsequent total disability leading to his death. Prior to his death the erroneous personnel action was corrected and the employee received a check for the amount by which his salary had been reduced. The claim was denied

because the employee's cardiac arrest was not "closely associated with his job duties." The Board found that the employee's cardiac arrest and subsequent disability leading to his demise was an injury sustained in the performance of duty.

The Board noted that Cannon was unlike Cutler because the employee was not aspiring to change his working conditions or status. He was immediately concerned about a direct, unanticipated and erroneous action by the employing establishment affecting the conditions of his employment. His emotional reaction could not be considered self-generated because the action by the employing establishment affected the conditions of his employment; neither could it be considered self-generated because the action by the employing establishment was directed to a particular employee on an official basis, and later found to be erroneous. Therefore, his cardiac arrest and subsequent death constituted an injury within the meaning of the Act.

Where the evidence shows error or abuse by the employing establishment, an employee's reaction cannot be considered self-generated and will come within the coverage of the Act. However, a reversal or modification of a disciplinary or other action taken against an employee does not necessarily establish that the employing agency's actions were in error or abusive. In Nicholas D. Buckley, Docket No. 91-673, issued October 24, 1991 the Board stated:

> appellant has submitted medical evidence which attributed the aggravation of his preexisting emotional condition to his termination from the letter carrier position he held at the employing establishment following 60 days of his probationary period. The evidence does not establish, however, that appellant's disability arose within the performance of duty. The record establishes that appellant's separation from the postal service resulted from two letters of warning he received, for failure to obey a direct order and for missing a collection box, and a preventable motor-vehicle accident. Following his separation, appellant filed grievances which resulted in one letter of warning being removed from appellant's record, in order that he could apply for a mailhandler position, and the second letter of warning being reduced to an official discussion, a form of discipline at the employing agency. In taking these administrative actions, appellant has not introduced any evidence which would demonstrate that the employing establishment erred or acted abusively in these matters. There is no evidence of record in this case that the employing establishment did not act reasonably in the administration of these personnel matters. The fact that one disciplinary letter of warning was removed and the second letter of warning was reduced to a discussion does not establish that the disciplinary actions brought against appellant were in error.

g. Personnel Actions. Personnel actions may be canceled or modified through various procedures such as arbitration, grievance, etc., or disputes may be settled without prejudice to the position of any party. Cancellation or modification of personnel actions and settlements of disputes do not, of themselves, establish that the actions were erroneous or unreasonable and therefore constitute factors of the employment. Affirming the Office's decision in William Cook, Docket No. 90-1343, issued November 30, 1990, the Board stated:

> appellant attributes his emotional condition to certain events and circumstances that occurred while he was a postal employee. These events and circumstances, although contemporaneous or coincident with appellant's employment, do not constitute factors of employment giving rise to coverage under the Federal Employees' Compensation Act. Appellant primarily complains that he has been the subject of long-standing harassment and discrimination from superiors and fellow employees, and he notes that he has filed complaints with the NLRB and EEOC, and numerous grievances. Yet, the record discloses no finding by the NLRB or EEOC to support appellant's assertions, and it appears that his grievances have yielded nothing more favorable than settlements without prejudice to the position of any party. The evidence does not establish that appellant was in fact the subject of harassment or discrimination.

Requirements imposed by the employment are not limited to assigned duties as such. Other circumstances relating to assigned duties may become part of the employee's employment and be sufficient to bring an injury or illness within the coverage of the Act.

In Pasquale Frisina, 34 ECAB 1230, the employee claimed that his emotional condition resulted from his receipt of an employing establishment letter criticizing his wife for the method of reporting his illness (telephone request to supervisor for sick leave). The employing establishment had procedures for reporting sick leave and returning to work. The employee's method for reporting sick leave had been questioned in the past. Citing 5 CFR 630.101, which charges agency heads with the responsibility for administering sick leave accounts for employees and provides how employees shall apply for sick leave, the Board found that the procedure for reporting sick leave was a requirement imposed by the employment. According to the Board the circumstances leading to the employee's alleged emotional reaction (wife's request on his behalf for sick leave; receipt of employing establishment letter) were part of the employment and related to the duties the employee was employed to perform and to the requirements imposed by the employment.
The Board reached a different conclusion in Joseph C. DeDonato, 39 ECAB 1260. Appellant contended that his emotional disability was caused by several factors including the employing establishment's refusal to grant his application for sick leave. The Board found that all of the factors cited by appellant, including the denial of sick leave, were factors involving personnel matters which did not have such a relationship to his assigned duties so as to be regarded as arising out of and in the course of the employment. The Board distinguished its holding in Frisina by noting that "Frisina addresses the issue of a duty imposed upon the employee by required reporting instead of the issue in the instant case which addresses the administrative denial of leave, and which is purely a personnel matter."

Since both cases involve procedures which employees must follow in order to obtain sick leave, it was unclear why the Board considered the procedural requirements a "duty imposed upon the employee" in Frisina but "purely a personnel matter" in DeDonato (the Board noted in DeDonato that, in response to his written request for sick leave, the employee received an immediate response from the employing establishment instructing him to "comply with employing establishment regulations within five days since his current absence had exceeded three days"). The Office took the position that Frisina stood alone among cases of this type and that all circumstances related to the administration of leave were strictly personnel matters and not factors of the employment.

The Board clarified its position in Anthony A. Zarcone, 44 ECAB 751, finding that employment establishment requirements for the use of sick leave were not compensable factors of employment. In affirming the Office's decision that appellant had not met his burden of proof to establish that he sustained an injury in the performance of duty, the Board discussed its previous decisions in Cutler and Raymond H. Schulz, Jr., 23 ECAB 25. The Board stated:

> In the case of Pasquale Frisina, the Board stated that the procedure for reporting sick leave was a requirement imposed by the employment. It found, without explanation, that the circumstances presented were a part of the employment and related to the duties that the claimant was employed to perform and to the requirements imposed by the employment. This holding was not explained in light of the Board's prior decisions in Edgar Lloyd Pake, (33 ECAB 872) which found that the disapproval of a request for sick leave was not a compensable factor arising from the employment. Because there was no explanation of how the requirement related to the duties the claimant was hired to perform, Frisina implies that any "requirement" of employment constitutes a compensable factor of employment. Such a holding is too broad, as the above discussion of Lillian Cutler and Raymond H. Schulz, Jr., demonstrates. Accordingly, the Board expressly overrules Pasquale Frisina to the extent that it is inconsistent with Cutler, Pake and the holding herein. The Board notes that Pasquale Frisina was implicitly overruled in subsequent cases, notably Joseph C. DeDonato and Ralph O. Webster, (38 ECAB 521) which held that emotional conditions resulting from actions taken by the employing establishment in personnel matters such as use of leave are not sustained in the performance of duty.

The Board has thus made clear that requirements for use of sick leave are personnel matters, administrative in nature, and have no relationship to the duties the employee was hired to perform

h. Other Factors. The Board reiterates in its decisions the principles set forth in Cutler distinguishing between injuries or illnesses which have some connection with the employee's employment but do not result from the regular or special duties or a requirement imposed by the employment, and those that do. An employing establishment may take action against or relating to an employee because of

something the employee did while on the job, or in connection with the employment, or because of his or her activities as a private citizen, which may result in a claim by the employee or dependents. In such cases the CE must determine whether the employee's actions were related to the assigned duties and the requirements of the employment.

In Walter Asberry, Jr. 36 ECAB 686 (1985), the employee claimed that his emotional disability was the result 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 Helen Marrotte, claiming as widow of Walter E. Marrotte, 36 ECAB 670 (1985), the employee accepted stolen military clothing from a co-worker who claimed to have found it in a locker. The employee was found to have had no part in the theft, but he received a written reprimand for having in his possession military clothing not received through regular supply channels. He filed a grievance but died of cardiac arrest before hearing were concluded. The Board found that, regardless of whether the employee knew that the clothing had been stolen, his acceptance of it through other than official channels was unrelated to his regular day-to-day duties, his specifically assigned duties or to a requirement imposed by his employment, and therefore the proceedings instituted against him were not factors of his employment.

In Pauline Phillips 36 ECAB 377 (1984), the employee, a postmaster, signed a petition regarding a community problem, which lead to a complaint filed against her by a local businessman. She received notice from the Postal Service that the complaint would be investigated. She alleged that worry over this caused her to develop an anxiety reaction and congestive heart failure. No investigation was initiated and Postal Service officials assured the employee that no adverse action would be taken against her. In finding that the employee was not entitled to coverage under the Act, the Board noted that her emotional reaction allegedly resulted from a situation which did not involve her ability to perform her day-to-day duties, or a special assignment, or because of a requirement imposed by the employing establishment. The situation arose because she exercised her rights as a private citizen.

The Board noted a similarity to the case of Manuel W. Vetti, 33 ECAB 750 (1982), a postmaster who developed a disabling emotional condition due to his reaction in an investigation involving a sale to the employing establishment of a parcel of land in which he had an interest. The Board found that the fact that the investigation would not have been initiated if Vetti were not a postmaster was "not a sufficient link to employment to consider his emotional reaction to it to have arisen out of the employment."

Ashberry's disability was not compensable because it had its origin in his willful misconduct. Marrotte's failure to conform to official procedures removed him from the coverage of the Act. Phillips' claim stemmed from her actions as a private citizen and the fact that she was the postmaster was insufficient to consider her disability as having arisen out of her employment.

i. Distinguishing Among Factors and Non-Factors of Employment. In George Derderian, 33 ECAB 1910, issued September 16, 1982, the employee alleged numerous causes of his emotional condition, all of which had some connection with his employment but not all of which could be deemed conditions of his employment. In its remand order the Board stated that situations which could be deemed conditions of employment as enunciated in Cutler were the employee's emotional reaction to the circumstances of his performance rating; confrontations with his supervisor involving criticism and other verbal altercations concerning his performance; the employee's assignment to a special project and its subsequent cancellation; legal action taken against the employee by a subordinate for his failure to promote the subordinate; and the employing establishment's failure to arrange for the employee's defense in the ensuing lawsuit causing him to retain private counsel. Factors which were not compensable under Cutler were distress over reduction-in-force and the appeals process which followed; distress over a newly created position and the national advertisement of that position; and distress over the assignment of one of the employee's subordinates as his acting supervisor.

The Board's finding that Derderian's emotional reaction to the circumstances of his performance rating resulted from his employment preceded the Board's clarification of its McEuen decision that an unsatisfactory performance rating, without more, is insufficient to provide coverage. Therefore, Derderian does not apply to claims which involve an emotional reaction to performance evaluations or assessments or to discussions of performance. McEuen is considered to be the definitive opinion with regard to the compensability of performance evaluations, assessments or discussions and is the basis for Office policy that these are not deemed conditions of employment.

j. Developing Factors of Employment. An employee who claims to have had an emotional reaction to conditions of employment must identify those conditions. The CE must carefully develop and analyze the identified employment incidents to determine whether or not they in fact occurred and if they occurred whether they constitute factors of the employment. When an incident or incidents are the alleged cause of disability, the CE must obtain from the claimant, agency personnel and others, such as witnesses to the incident, a statement relating in detail exactly what was said and done. If any of the statements are vague or lacking detail, the responsible person should be requested to submit a supplemental statement clarifying the meaning or correcting the omission.

When all available evidence has been obtained, the CE must prepare an objective and neutral account of the facts (Statement of Accepted Facts, or SOAF). Where the evidence is in conflict, the CE must decide which is the best supported and most likely version. The CE must distinguish in the SOAF between those activities and circumstances which are factors of employment and those which are not (see PM Chapter 2-809.13c). The evaluating physician will be required to give a rationalized opinion specifying which activities and circumstances, as set forth in the statement of accepted facts, caused or contributed to the condition found on examination.

The determining factor in the types of cases discussed in this section is whether the alleged disability resulted from an incident or incidents which are sufficiently connected to the employment to be considered factors of the employment. To make this determination, the CE must fully develop the circumstances of the alleged injury as well as the employee's duties and working conditions. This will include not only those duties specifically defined (official position description) but also implied (not specifically defined but expected by the employing establishment), if any. Where a claim is filed because of an incident which appears to have no direct relationship to an employee's regular or specially assigned duties, the CE must decide whether a requirement imposed by the employment was involved that, under the circumstances, would be considered part of the employment.

Claims filed for injury or illness allegedly due to employing establishment actions against or relating to an employee solely because of willful misconduct, failure to conform to or violation of official agency procedures, or an employee's actions as a private citizen, do not have the coverage of the Act because the injury or illness does not result from the employee's regular or special duties or a requirement imposed by the employment. These situations are not the result of work performance, but of a type of behavior which removes the employee from the performance of duty. Claims filed for emotional reactions to personnel actions such as performance evaluations and administration of leave also do not have the coverage of the Act. Where the evidence, after proper development, shows the existence of any of the described situations, and requirements for time, civil employee and fact of injury have been met, the claim will be denied for failure to meet the performance of duty requirement.

CEs must become familiar with significant Board decisions in this area and apply the

established precedents to new cases. In addition to the cases cited above, CEs should note Carol Medlinger, 29 ECAB 168, and Kenneth Vreeland, 12 ECAB 281.

k. Rescission. In some claims, factors which were originally accepted as work-related would no longer be considered so in light of the ECAB decisions quoted above. Therefore, it may sometimes be necessary to rescind a claim where the acceptance was based on factors which are no longer considered to fall within performance of duty. Decisions to rescind acceptance of a claim will be made only by journey-level CEs and above.

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision. (Eli Jacobs, 32 ECAB 1147). To justify rescission of acceptance, the Office must establish that its prior acceptance was erroneous based on a new or different evidence or through new legal argument and/or rationale as was done in the case of Curtis Hall, Docket No. 92-683, issued January 11, 1994.

In that case, appellant claimed an employment-related disabling emotional condition which he attributed to a confrontation with a coworker who objected to his bible reading during work breaks. He also alleged a previous incident when a toxic substance had been placed in his chair causing contact dermatitis, diabetes mellitus and hypertension. The Office accepted appellant's claim for a depressive reaction based solely upon medical opinion evidence without determining whether his allegations were supported by the factual evidence of record.

After appellant's claim was accepted, the employing establishment physician submitted a report to the Office which stated that appellant had sat on his own super glue pen container, which was not issued and used in his job, and that the incident would not cause hypertension or diabetes mellitus. On further review, the Office found that appellant's emotional condition did not arise out of factors of his federal employment, and that the medical opinion evidence on causal relationship was unrationalized.

An office hearing representative found that the alleged incidents of confrontation and placement of super glue on appellant's chair were not established as factual; that the medical reports of appellant's attending physician were based on an inaccurate history and therefore of little probative value; and that the reports of the physicians of record did not find appellant disabled for his position.

The Board found that the Office met its burden of proof to rescind its acceptance of this claim based on new medical evidence and the provision of new legal rationale that the implicated work related incidents were not established as factual.

When it has been determined that only correct and proper application of personnel and administrative matters were involved in a case accepted for emotional disability, the acceptance may be rescinded based on new legal argument that no employment factors were involved, without the need for new evidence. In those cases the CE will prepare a Memorandum to the Director which will include:

(1) A summary of the development and adjudication of the claim, noting that the Office had not previously considered whether the employment circumstances which caused the claimant's emotional reaction were factors of the employment.

(2) A description of the employment circumstances which caused the claimant's emotional reaction with an explanation of why they do not constitute employment factors, citing pertinent Board decisions.

(3) A recommendation to rescind acceptance of the claim based on new legal argument that, since the circumstances to which the claimant attributes emotional problems do not constitute factors of employment, disability did not arise out of the employment or in the performance of duty, and the employee has not sustained an injury within the meaning of the Act.

If the claimant does not respond to the pre-termination notice, or if the claimant's response is not sufficient to change the Office's position or to require further development of the record by the Office, a formal decision will be issued rescinding acceptance of the claim and terminating benefits on the ground that acceptance of the claim was incorrect because the circumstances to which the claimant attributes his or her emotional disability are not factors of the employment within the meaning of the Act and the claimant's disability did not arise out of in the course of his or her employment and he or she was not injured in the performance of duty.

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

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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) A nurse becomes disabled by pulmonary tuberculosis after a year of continuous employment on a ward where active tuberculosis patients were housed. If all other factors were negative, any medical opinion supporting causal relationship would require little or no rationale, as it would be apparent that the most probable source of the infection was in the employment.

If, however, investigation had revealed that the employee lived with a spouse in whom an advanced case of active pulmonary tuberculosis had been discovered 60 days before, two probable sources of the infection exist: the hospital where the employee was exposed for 40 hours per week in an atmosphere where the hazard was known and appropriate precautions were taken; and the home, where the hazard was unknown and no precautions were taken and where the contact was much more intimate and far exceeded 40 hours per week.

Under these circumstances, it would be more difficult to find that the employment was a proximate cause of the disease and any medical opinion in support of causal relationship would require a full description of the medical reasons justifying such an opinion.

Another variation involves the supposition of massive exposure at work and no exposure in private life, but with a positive skin test for tuberculosis prior to Federal employment. The major question then would be whether the current illness is a new disease process or a reactivation of an old one. This issue would require careful consideration, and any opinion which did not discuss all relevant factors and contain detailed rationale would not be sufficient to serve as the basis for 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 INITIAL ACCEPTANCES

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Chapter 2-0806, Initial Acceptances

1. Purpose and Scope. This chapter contains procedures for the initial acceptance of claims. It supplements information about developing claims (FECA PM 2-0800), the five basic requirements of a claim (FECA PM 2-0801 through 2-0805), weighing medical evidence (FECA PM 2-0810), and disability management (FECA PM 2-0600). Also, see FECA PM 2-1400 for a detailed discussion of disallowances.

2. Accepting the Claim. In adjudicating the case, the CE must review and evaluate all material submitted to determine whether the case meets the five basic requirements for a claim under the FECA (timeliness, civil employee, fact of injury, performance of duty, causal relationship). If the evidence is sufficient to establish that the five basic requirements have been met, the CE should take the following actions:

a. Determine what diagnosis or diagnoses to accept based on the medical documentation of record, and identify the corresponding International Classification of Diseases (ICD) codes.

(1) The CE should accept each diagnosis that is causally related to the work injury, regardless of severity or impact on disability. Cases with multiple medical conditions are further addressed in paragraph 4 of this chapter.

(2) If the medical evidence establishes that a pre-existing condition was aggravated, an aggravation should be accepted, not the underlying condition itself.

b. In traumatic injury cases, determine if Continuation of Pay (COP) is payable. If COP has been claimed but is not payable, the CE should release a formal decision with appeal rights denying COP. In occupational disease cases, and in those cases where the claimant is not entitled to COP but has lost wages as identified by the receipt of Form CA-7, the CE should determine if compensation is payable in accordance with timely payment procedures. See FECA PM 2-0807 for further discussion of COP and PM 2-0901 for further discussion of initial payment of compensation.

c. Enter the accepted condition(s) (i.e., ICD-9 code(s)) and the correct case status and adjudication status codes into the Integrated Federal Employees' Compensation System (iFECS). See FECA PM 2-0401 for details about case status and adjudication status codes.

d. Advise the claimant by letter of the condition(s) accepted. A letter should be issued in all formally adjudicated and accepted cases, without exception. The letter should include the date of injury, name of the employer, accepted work-related condition(s), information regarding entitlement to COP (if applicable), and instructions for filing a wage-loss claim (if applicable). A copy of the letter should be

sent to the employing agency, and to the claimant's representative, if applicable.

e. If the employing agency has challenged the claim and/or controverted COP, and such challenge or controversion is not upheld, the CE must acknowledge and respond to the challenge either in the acceptance letter or by separate correspondence. Responding to challenges is further discussed in paragraph 7 of this chapter.

f. Review the case to determine if the potential for third party liability exists. If third party potential exists, the CE should initiate third party subrogation procedures in accordance with FECA PM 2-1100.

g. Review the case to determine if Disability Management actions are needed. See paragraph 3 of this chapter.

3. Disability Management Upon Acceptance. At the time the claim is accepted, the CE should ascertain the claimant's current work status if it is not clear in the file.

If the claimant is losing time from work, the CE should initiate disability management actions in accordance with FECA PM 2-0600. If the claimant is working in a limited duty capacity without wage loss because of the accepted work injury, disability management actions may also begin.

If upon acceptance, it is clear that disability management is needed because the claimant has not returned to work, the CE should advise the claimant in the acceptance letter that OWCP is evaluating the case to determine what steps are necessary to facilitate medical recovery and sustainable return to work; such notice will prepare the claimant for the upcoming disability intervention actions.

4. Multiple Medical Conditions. In many cases, the claimant will claim multiple conditions on the CA-1 or CA-2. The CE should ensure that all claimed conditions are addressed at the time of initial adjudication. The action taken by the CE will depend on whether each claimed condition has been properly developed.

a. If all claimed conditions have been developed, and the evidence of record supports acceptance of some but not all of the conditions claimed, the CE should issue an acceptance letter for the compensable conditions and issue a formal decision with appeal rights denying the remaining claimed conditions. Like any other formal denial, this decision must make findings of fact and include appeal rights.

b. If multiple conditions have been claimed, the evidence submitted supports acceptance of some but not all of the conditions, and the remaining conditions have not been developed, the CE should issue an acceptance letter for the compensable conditions and concurrently issue a development letter for the remaining claimed conditions. The development may be undertaken in either the acceptance letter itself or by separate correspondence.

c. In some instances, the claimant may claim only one medical condition, while the medical evidence indicates that multiple diagnosed conditions are work-related. The CE should accept each diagnosis related to the work injury, regardless of severity or impact on disability. For example, a claimant slips and falls on ice in the course of employment, and a left hip contusion and left knee medial meniscus tear are diagnosed by a physician in the emergency room. Even if the left knee condition becomes the predominant cause for disability and need for further treatment, the CE should also accept the left hip contusion, assuming the five basic requirements are met.

5. Resolved Conditions. In some instances the medical evidence will support that a condition being accepted at the time of adjudication has already resolved. In these situations, a determination regarding ongoing entitlement may be addressed in the acceptance letter. This is particularly important if there is evidence of ongoing treatment for another non-work related, but similar, condition.

In this instance, the CE cannot state that the work-related condition has resolved and close the case without providing the claimant the opportunity to exercise appeal rights. For this reason, the CE must cite the evidence that demonstrates the condition has resolved in the acceptance letter, attach a copy of the medical evidence to the acceptance letter, and include appeal rights. For medical bill processing purposes, the case should first be adjudicated for the acceptance with appropriate case status and adjudication codes, before updating iFECS with the final coding of C3/D5.

Where multiple conditions have been accepted, the medical evidence may support that one or more condition has resolved while residuals are ongoing for remaining accepted conditions. Such cases should be open for benefits related to the ongoing accepted conditions while finding no further entitlement for those conditions which have resolved.

The following sample language may be used when an accepted condition has clearly resolved: Your claim has been accepted for a cervical strain, resolved by April 1, 2011. In a report dated April 1, 2011, your treating physician stated that your examination resulted in normal findings and the cervical strain had completely resolved. A copy of this April 1, 2011 report is enclosed. Therefore, no further benefits for a cervical strain will be covered after the date of this letter.If you disagree, please refer to the attached appeal rights.

6. Accepting and Simultaneously Closing a Case. The Office should administratively close a case at the time of adjudication if the treating physician has released the claimant from care and/or advised the claimant to return only on an as-needed, or "prn," basis. This often occurs with minor conditions such as sprains/strains and contusions.

The CE should properly notify the claimant in the acceptance letter that the case has been closed. Appeal rights need not be attached, as such a closure is not a termination of benefits and would still allow the claimant to pursue reopening his or her claim (e.g. by filing Form CA-2a, Notice of Recurrence). For medical bill processing purposes, the case should first be adjudicated with appropriate case status and adjudication status codes and saved before updating the final coding to C5/AM.

Sample language: On April 16, 2011, your physician released you from care to return on an as-needed (prn) basis. Therefore, your case has been administratively closed with no need for further medical care anticipated. This will allow authorized medical bills submitted for payment to be processed for a period of 120 days from the date of this letter. Form CA-2a, Notice of Recurrence, may be filed in the event further medical care is needed.

7. Addressing Employing Agency Challenges/Controversions. A controversion is an employing agency's dispute, challenge, or denial of the validity of a claim for COP. An employing agency may controvert COP based on one of nine statutory exclusions (see FECA PM 2-0807) or challenge the claim as a whole based on other objections associated with the five basic requirements for FECA coverage. The term "controversion" applies specifically to the issue of COP. The agency may pay COP but challenge the claim itself; controvert COP (based on a statutory exclusion) but not challenge the claim; or controvert COP and challenge the claim.

The CE must be mindful of the nature, strength and logic of the employing agency's objection and thoroughly develop the controversion or challenge if necessary. A controversion or challenge can be addressed in the development letter or acceptance letter with a copy to the employing agency or in a separate narrative letter to the agency.

The CE must provide a response to the employing agency's challenge or controversion if the claim is accepted and COP is approved. This would also include situations where no specific reason or argument is provided by the agency in support of its objection. The CE should provide such notification within the body of the acceptance letter or by separate letter. In some instances it will be more appropriate to notify the agency by separate letter or by using Form Letter CA-1038; however, notification should be provided at the time of acceptance. The CE should sufficiently explain the basis for approving COP or the claim by specifically referencing each challenge and explaining how the evidence of record was used

to support the acceptance of the case. The facts or dates of medical reports which led to the determination should be clearly stated.

Sample language to Employing Agency addressing a challenge of a claim: It is noted that you challenged this claim due to a lack of medical evidence establishing causal relationship. The evidence, however, supports that this employee is a Federal employee who sustained a traumatic injury in the performance of duty; therefore, the case has been accepted. Even though you indicated that there was a lack of medical evidence, we have received a report from Dr. John Smith dated March 31, 2011 supporting causal relationship in this case. The injury was clearly established (the claimant fell on ice) and the attending physician diagnosed a right knee meniscus tear as a result of the injury.

8. Aggravation of a Medical Condition. A claimant may sustain an aggravation of a pre-existing condition due to an injury arising in the course of employment. This could result from a traumatic event or exposure to hazardous conditions.

In determining whether a pre-existing medical condition has been aggravated by an injury or by job duties, causal relationship can only be established by medical evidence. Where medical evidence establishes that a pre-existing condition was aggravated, an aggravation should be accepted, not the underlying condition. The CE should accept either a temporary or permanent aggravation, depending on the medical evidence of record. A permanent aggravation should only be accepted after careful evaluation of the weight of the medical evidence of record, as discussed in FECA PM 2-0805.

A CE can neither diagnose nor medically determine the extent and duration of an aggravation or any disability associated with the aggravation. This determination must be made based on the medical evidence. The extent and duration of work-related aggravation is one of the critical areas that should always be developed when an aggravation is diagnosed.

The CE should define in the acceptance letter exactly what type of aggravation is being accepted, whether temporary or permanent. If the accepted aggravation has ceased, the acceptance letter should state the date that the accepted aggravation is considered to have ended by citing the specific medical evidence used to make that determination. The CE should also consider whether the case is in posture for termination of ongoing benefits at the time of acceptance, in which case appeal rights must be attached (see paragraph 5 of the chapter). If it remains unclear whether the temporary aggravation has resolved, the CE should include questions to the attending physician (or write to the physician directly) at the time of acceptance in order to develop when the temporary aggravation is expected to subside or return to baseline, or pre-injury, status.

If the aggravation is temporary and leaves no permanent residuals, the claimant is entitled to compensation only for the period of disability related to the aggravation. This is true even when the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing

condition. When the claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, compensation is no longer payable.

The Employees' Compensation Appeals Board (ECAB) has held that where an employee claims an aggravation of a preexisting condition, the employee must provide a rationalized medical opinion discussing the nature of the condition, including its natural or traditional course, and how the underlying condition was affected by the employment. See Newton Ky Chung (39 ECAB 919___ (1988) and Raquel Navedo-Cruz, Docket No. 96-1558; Issued May 1, 1998).

9. Risk of Future Exposure. Generally speaking, a wage-loss claim due to the risk of future exposure or prevention of future injury (prophylactic measures) is not compensable.

When an employee cannot work due to risk of future exposure, the CE must determine whether the susceptibility is due to the employee's exposure on the job site, or if it pre-existed such exposure. Such disability is compensable only if it is due to exposure on the job.

As ECAB held in Dennis L. O'Neill (29 ECAB 151) and clarified in James L. Hearn (29 ECAB 278), when an employee has suffered a work-related injury which results in permanent residuals, disability for work may result when additional exposure to the implicated employment conditions would further endanger the employee's health, although the residuals of the injury alone might not be disabling.

For instance, since exposure to asbestos dust generally results in permanent and irreversible changes in the pulmonary system, medical evidence may state that continued employment in a certain job or work environment is contraindicated due to the dangers of continued exposure. If the employing agency cannot provide employment in an environment that conforms to the medically allowed level, the claimant will be entitled to compensation. If the impairment is sufficient to disable the individual for his or her customary employment, the CE should refer the claimant for vocational rehabilitation services.

On the other hand, if employment factors aggravate a pre-existing condition, the claimant is entitled only to compensation for the period of disability related to the aggravation, if the aggravation is temporary and leaves no permanent residuals. This is true even if the claimant is found medically disqualified to continue in his or her regular job because of the effect which the employment factors might have on the pre-existing condition. The claimant's inability to continue working is due to the underlying condition, without any contribution from the employment, and therefore compensation is not payable.

2-0807 CONTINUATION OF PAY AND INITIAL

PAYMENTS

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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 FormCA-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

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*(ENTIRE CHAPTER REISSUED 01/10, TRANSMITTAL NO. 10-04)

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 and total in nature. Only in catastrophic injuries or long-standing chronic conditions should this course be considered, and then only after all attempts to reemploy and/or rehabilitate the claimant have been exhausted.

b. Permanent Partial Disability (PPD). In disability which is permanent in nature but only partial, compensation is based on the difference between the wages earned at the time of injury, disability, or recurrence, and the wages the claimant is capable of earning after the injury. This difference is called loss of wage-earning capacity (LWEC). Reemploying injured workers and establishing LWEC are discussed in FECA PM 2-0813 and 2-0814.

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 reminders be set at appropriate intervention points according to the medical evidence. The Claims Examiner (CE) should also 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, or the equivalent, 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. See 5 U.S.C. 8105 (b). 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 District Medical Advisor (DMA). Such an award does not supersede any award which may be payable for a schedule disability. Whenever a case involves both permanent total disability and schedule impairment, the CE should pay the schedule award and then continue compensation for permanent and total disability at the expiration of the schedule award.

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 10.404.

(2) In some instances a schedule award may be payable even if the claimant had a pre-existing loss or loss of use of 100 percent of a member or function of the body. Cases of this type should be developed to determine the prior usefulness of the member or function and whether the injury in Federal employment has diminished any such usefulness, in whole or in part.

(3) A schedule award is payable consecutively but not concurrently with an award for wage loss for 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 and/or extremity. For example, a claimant is currently receiving a schedule award for 10% permanent partial impairment of the right arm due to a work-related right rotator cuff tear. The claimant files for temporary total disability under another claim for the same period due to undergoing right carpal tunnel surgery. Compensation claimed for temporary total disability cannot be paid since compensation involves the same extremity, the right arm. See JB, Docket No. 08-1178 issued December 22, 2008; and VP, Docket No. 07-1158 issued December 17, 2007.

(5) Schedule awards unpaid at death. Under 5 U.S.C. 8109, if an individual has sustained impairment compensable under section 8107(a) of this title; has filed a valid claim in his lifetime; and dies from a cause other than the injury before the end of the period specified by the schedule, the compensation specified by the schedule that is unpaid at his death, whether or not accrued or due at his death, shall be paid in accordance with the order

of precedence specified by the statute. See Sandra Henley, Docket No. 00-1619 issued April 4, 2002. (The ECAB affirmed the denial of a schedule award benefit to a widow where her husband who was injured in a terrorist bombing had not filed a claim for a schedule award during his lifetime. The ECAB found a valid claim (in writing and with words of claim) filed by the employee or someone on his behalf must be made during the employee's lifetime.)

b. History of Entitlement. Entitlement to schedule awards has been affected by various legislative changes over the years. Following is a description of coverage afforded by the FECA during various periods according to date of injury:

(1) Prior to December 7, 1940. No provision for schedule award.

(2) December 7, 1940 to September 12, 1957. Schedule award for 100 percent loss or loss of use of major members only; injury must be to schedule member itself. No entitlement to compensation for loss of wage-earning capacity after expiration of the award. (On October 14, 1949, the law was amended such that schedule awards were payable retroactively to October 14, 1948 for "minor" impairments, such as simple fractures, and retroactive to January 1, 1940 for "major" impairments, such as amputations of hands or feet or loss of vision.)

(3) September 13, 1957 to July 3, 1966. Broadened coverage such that schedule impairment did not have to be the only residual of the injury. Permanent impairment had to be confined to the schedule member, however, so that if any other "significant disability" existed (i.e., any which would require treatment or cause loss of wage-earning capacity), no schedule award was payable. However, an employee who had a significant permanent impairment of a portion of the body not covered by the schedule provisions (i.e. back) in addition to the loss or loss of use of a schedule member (i.e. arm) could not receive both a schedule award for the schedule member in addition to compensation for the loss of wage-earning capacity of the non-schedule member. In such a case, compensation could only be paid on the basis of loss of wage-earning capacity.

(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." Schedule award available regardless of whether the injury resulted in impairment to a nonscheduled member (i.e. back) in addition to the loss or loss of use of a schedule member (i.e. arm). Provision explicitly permitted payment of both schedule and disability compensation in such circumstances. (Provision was not made retroactive to any injuries sustained prior to July 4, 1966.)

(5) September 7, 1974 to present. FECA amended to provide for schedule awards payable for internal organs specified by the Secretary in addition to

those indicated in the FECA. See 5 U.S.C. 8107 (22). The Secretary has added by regulation the following organs: the breast, kidney, larynx, lung, penis, testicle, tongue, ovary, uterus/cervix and vulva/vagina. 20 C.F.R. 404.

2-0808-6 Evaluation of Schedule Awards

6. Evaluation of Schedule Awards.

a. Methods of Evaluation. For impairment ratings calculated on and after May 1, 2009, CEs should advise any physician evaluating permanent impairment to use the American Medical Association's Guides to the Evaluation of Permanent Impairment, Sixth Edition, and to report findings in accordance with those guidelines except as noted below. (Also, see FECA PM 3-0700.)

(1) Impairment to the lungs should be evaluated in accordance with the Guides insofar as possible. The percentage of "whole man" impairment will be multiplied by 312 weeks (twice the award for loss of function of one lung) to obtain the number of weeks payable; all such awards will be based on the loss of use of both lungs.

In cases involving anatomical loss by traumatic injury or surgery, the evaluation will also be based on loss of lung tissue by weight or volume, and the award will be based on these factors if it results in a greater percentage of loss than one based on loss of respiratory function. Anatomical loss awards will be made for one or both lungs as appropriate.

(2) Impairment due to pain. Impairment applicable to pain is inclusive as a component of the medical condition (diagnosis) and not measured separately unless the pain does not correlate with objective findings or body part dysfunction. Chapter 3 of the Guides discusses evaluation of pain if it is not classifiable in the diagnosis based impairment. An example would be fibromyalgia or pain due to a sprain where no objective findings or identifiable abnormalities are noted. In no circumstances though should the pain-related impairment developed under Chapter 3 be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 – 17. When pain is the sole impairment, the physician should have the claimant complete Appendix 3-1 of the AMA Guidelines, Sixth Edition - Pain Disability Questionnaire (PDQ), or obtain the necessary information in some other format.

(3) Impairment resulting from an injury to the spine. While the FECA does not allow payment for impairment to the spine, a schedule award can be paid for the extremities if a spinal injury leads to impairment of the arms or legs. Impairment to the upper or lower extremities that is caused by a spinal injury should be rated consistent with the article "Rating Spinal Nerve Extremity Impairment Using the Sixth Edition" in the July/August 2009 edition of the The Guides Newsletter published by the AMA. This newsletter, which has been reproduced with the permission of the AMA, is Exhibit 4 in PM 3-0700.

b. Evidence Required. To support a schedule award, the file must contain competent medical evidence which:

(1) Shows that the impairment has reached a permanent and fixed state and indicates the date on which this occurred ("date of maximum medical improvement" or MMI);

(2) Describes the impairment in sufficient detail for the CE to visualize the character and degree of disability; and

(3) Gives a percentage of impairment based on a specific diagnosis, not the body as a whole (except for impairment to the lungs). In members with dual functions, the physician should address both functions according to the AMA Guides.

c. 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 report that includes history of clinical presentation, physical findings, functional history, clinical studies or objective tests, analysis of findings, and the appropriate impairment based on the most significant diagnosis, as well as a discussion of how the impairment rating was calculated.

(2) Impairment due to amputation is based on the level of the amputation. The physician's report must include functional history, physical examination and clinical studies. Impairment based on proximal diagnosis or range of motion may be combined with the amputation impairment. However, the physician must explain the reasoning for combining the additional impairment.

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, Sixth 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, 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 2-0901. The CE should key the payment in the case management system and prepare Form CA-181 (or equivalent), Award of Compensation.

The CE should keep in mind the following considerations in setting up a schedule award:

(1) The MMI date is determined solely on the basis of the medical evidence. However, a subsequent date may be chosen to start the award if the DMI falls within a period of compensable disability such that converting disability payments into a schedule award would be disadvantageous to the claimant. See Franklin L. Armfield, 28 ECAB 445 (1977).

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 (1976).

(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 (and a schedule award has been granted for such prior impairment), in which case the percentage already paid is subtracted from the total percentage of impairment; or

(b) The VA has already paid a claimant for a previous impairment to the same member, in which case an election will be required if the VA has increased the percentage payable due to the injury in civilian employment. In this instance, an election will be 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 award, 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 award in order to pay for the period of recurrence. If a recurrent pay rate is established, the claimant will be entitled to that rate for the balance of the schedule award after the period of disability attributable to the recurrence has ceased.

(4) 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 (1977)). 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 TTD. It is therefore not necessary to interrupt a schedule award for payment of TTD unless the claimant is also receiving an annuity from OPM. In this case the payments must be converted to TTD and an election must be obtained, as vocational rehabilitation services cannot be provided to an individual in receipt of such an annuity.

(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 (1979)). 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 into the future, 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.

(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 Sixth Edition. Should the subsequent calculation result in a percentage of impairment lower than the original award (as sometimes occurs), a finding should be made that the claimant has no more than the percentage of impairment originally awarded, that the evidence does not establish an increased impairment, and that the Office has no basis for declaring an overpayment. Similarly, awards made prior to May 1, 2009 (the effective date for use of the Sixth Edition) should not be reconsidered merely on the basis that the Guides have changed. (All permanent partial impairment calculations made on or after May 1, 2009 must be based on the Sixth 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 for hearing loss.

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. 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.

2-0809 STATEMENTS OF ACCEPTED FACTS

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***(ENTIRE CHAPTER REISSUED 09/09, TRANSMITTAL 09-07)**

Exhibits

2-0809-1 Purpose and Scope

1. Purpose and Scope. This chapter contains guidelines for the preparation of statements of accepted facts (SOAFs). The SOAF is a concise summary of the relevant facts that will allow a physician to resolve a particular medical issue. The SOAF can be useful to assist the attending physician, a second opinion examiner, a referee medical examiner, the District Medical Advisor, Rehabilitation Counselors, Nurse Case Managers, employing agencies, and others interested in the facts used by the Office to make determinations about a case.

An accurate and complete SOAF requires that the factual issues pertinent to the claim be properly developed, weighed and resolved in advance. For information about the development of particular issues, refer to FECA PM 2-0800, Development of Claims, and the ensuing chapters addressing the five basic requirements, or to FECA PM 2-0700, Death Claims.

For a discussion of formulating medical questions and forwarding cases for medical opinion

when the SOAF is completed, refer to FECA PM 2-0810, Developing and Weighing Medical Evidence and FECA PM Part 3, Medical.

2-0809-2 Introduction

2. Introduction. The SOAF is one of the most important documents a Claims Examiner (CE) prepares. It is the written summary of the CE's findings of facts. It serves as a factual frame of reference for the medical specialist, the CE or other case reviewer. When it is used by physicians who base their medical opinions solely on the information presented in the SOAF, the outcome of a claim may depend on its completeness and accuracy. Therefore, the SOAF must clearly and accurately address the relevant information.

a. The SOAF represents what the OWCP in its capacity as fact finder has accepted as factual in a particular case. In Leopold J. Gunston, 15 ECAB 83 (1963), the ECAB stated:

> A statement of accepted facts is not a counterpart of a "stipulation of facts" between adversarial parties in court procedure. In the determination of facts in a claim for compensation, the [OWCP] is acting in its adjudicatory function as a trier of the facts.

Given the variation in the factual events which occur in some compensation claims, the number of issues to be resolved, and the differing courses of medical development, the CE will need to assess the relevance and validity of factual evidence and how it should be presented in the SOAF. While some elements will be common to all SOAFs, inclusion of others will depend on the issue to be resolved and the history of the injury. The SOAFs prepared in psychological/emotional stress claims are inherently different from all other types.

b. The SOAF provides the physician a framework from which to formulate an opinion regarding a particular medical issue or question. It allows the physician to place the medical questions posed in the larger context of the mechanism of injury, the requirements of the claimant's job, or the conditions which prevailed in the workplace. It may also provide the physician with a chronology of events after the injury.

c. The SOAF is also the means by which factual findings are separated from medical findings and opinions. This separation of functions is aimed at seeing that the CE does not inadvertently make medical decisions. Similarly, properly written SOAFs demonstrate to physicians what OWCP has accepted as factual; clear factual findings are aimed at preventing physicians from making erroneous factual assumptions about the case, which could undermine their medical conclusions.

d. In certain circumstances SOAFs are required, and in other situations the CE may elect to prepare them:

(1) All issues requiring a medical opinion for resolution, except for those which do not depend on the facts of the claim, should have SOAFs. For example, a request for surgery for repair of a broken bone where causal

relationship is not an issue would not necessarily require a SOAF. Issues commonly referred for medical opinion where a SOAF may be required or useful include causal relationship, extent and duration of disability, percentage of impairment, and appropriateness of care.

(2) To assist an attending physician in formulating a well-founded medical opinion, the CE may provide the physician with a SOAF and relevant questions. A SOAF would be particularly indicated in a situation where the facts as related to or by the physician differ from those accepted by OWCP. A CE should provide a SOAF when OWCP has evidence such as exposure data not readily available to or verifiable by the physician.

(3) Due to the complex nature of psychological/emotional stress claims, this type of claim must have a SOAF written before adjudication. In psychological/emotional stress claims, the SOAF is particularly important since the physician's opinion on causal relationship must be based on an accurate identification of the implicated work factors. The SOAF is required in these claims even if the CE decides not to send the claimant for a second opinion medical examination at the time of adjudication. The complex nature of the issues inherent in this type of claim necessitates that the facts be established and documented in a SOAF.

2-0809-3 Responsibilities of the Claims Examiner

3. Responsibilities of the Claims Examiner. The CE has certain obligations both before and during preparation of the SOAF. In making findings, the CE is obliged to apply principles of logic and evidence. These guidelines for fact-finding may be based on legal principles of evidence, Larson's Workmen's Compensation Law, OWCP policies, and ECAB decisions. For more information on fact-finding, see FECA PM 2-0803, Fact of Injury.

a. The CE should first recognize that a medical issue(s) needs resolution and concisely define that issue. Issues may vary during the life of any claim, and a case may need multiple referrals for medical opinion.

b. The CE must thoroughly review the case to determine if there is sufficient evidence to establish the facts of the case. If the facts cannot be established, the CE is responsible for gathering all the information through development of the case. (See FECA PM 2-0800.)

c. The CE should define the information needed to form a complete frame of reference for the physician(s) who will review the medical evidence. Evidence which may be pertinent to the resolution of one issue may not have any bearing on the resolution of another. For example, a description of the physical requirements of the date of injury job would be relevant to the question of whether a claimant may return to regular duty work but has no relevance with regard to whether surgery is medically necessary.

d. If there is an apparent disagreement on the factual evidence, the CE may

wish to provide the interested parties an opportunity to comment on the evidence, statements and documentation submitted as well as a meaningful opportunity to rebut when allegations are made or conflicting evidence is received. In addition to seeing that the facts are known to the parties, this process is also a useful vehicle for developing the claim, refining the issues for the CE, and assisting in the resolution of conflicts prior to making findings of fact.

e. The CE must determine the facts in a case by weighing the evidence which has been developed and drawing conclusions based on that evidence. When the relevant information has been received and the parties to the claim have had a chance to refute any disputed evidence, the CE is ready to evaluate the evidence for credibility and validity.

Evidence can be classified as direct or indirect. The value of each varies and is not fixed for all circumstances. Because direct evidence represents a first-hand account (such as a witness statement), it is ordinarily assigned greater weight than indirect evidence, or second-hand knowledge of an event. However, while direct evidence is generally regarded as superior, it may be overridden by indirect evidence which is more plausible or internally consistent with all the other facts in a case. For this reason the CE must exercise discretion and logic in drawing conclusions or making inferences based on the factual information in a claim.

f. The CE must reach decisions based on the evidence which is received. As the adjudicator of the claim, the CE may not abdicate this responsibility to others, either within or outside the OWCP.

g. The CE must present a description of the employment injury or exposure as a definitive statement of fact without mention of the source from which the information was derived. In essence, the SOAF contains only what the CE has determined as factual. For example, in describing an event as fact, the statement would read that the claimant twisted his right ankle descending stairs, rather than the claimant "states," "claims" or "alleges" that he twisted his right ankle descending stairs.

h. The CE must set forth his or her findings in a clear, concise and orderly statement which is complete with respect to essential details and free of extraneous material. This is usually best accomplished by describing the facts in chronological order. The CE must consider all relevant evidence to ensure that the SOAF is complete and accurate. ECAB has remanded cases even when the omission of evidence from the SOAF may not materially affect the outcome. See Richard A. Sroka, 35 ECAB 209 (1983).

2-0809-4 Composition of SOAF

4. Composition of the SOAF. The CE must take several factors into consideration in constructing a thorough, accurate and complete SOAF. The SOAF is typically written in a narrative format, with facts presented in an orderly and logical manner. An orderly flow will ensure that readers are able to quickly understand the case's critical components.

For some types of claims, such as hearing loss and asbestosis, specific reporting forms have been developed. In psychological/emotional cases, a SOAF addressing specific elements is necessary (see Paragraph 5 below). Wherever possible, exposure data, job descriptions or duties, and other records should be condensed to essential information and incorporated into the body of the SOAF.

a. SOAF Writing Method and Style.

(1) All evidence on which the SOAF is based must be in the case record. The CE may not make findings based on an undocumented conversation or an investigative report which is not subject to examination or rebuttal. The CE must also avoid making findings based on similar evidence found in other case files (e.g., position descriptions).

(2) The SOAF should include a complete record of all pertinent facts related to the injury or medical condition. The omission of a critical fact diminishes the validity of a medical opinion or decision as much as an incorrect statement. Avoiding selective inclusion of facts in the SOAF prevents a perception of bias and maintains neutrality and objectivity in the management of the case.

(3) Facts should be presented in a chronological order so the reviewer can visualize the sequence of events.

(4) Whenever possible, workplace factors should be quantified so the physician can correlate the exposure with medical or scientific data on causality. Examples of quantifiable factual elements include:

(a) Period and length of exposure
(b) Decibel levels of exposure
(c) Concentration of asbestos fibers and other noxious substances in the air
(d) Weight and size of objects lifted
(e) Number of times a repetitive task is performed
(f) Frequency and type of workplace confrontations or encounters

A medical opinion based on an accurate SOAF has enhanced probative value, whereas an opinion based on incorrect or incomplete facts is of diminished value.

See T.G., Docket No. 07-2231 (issued June 2, 2008). ECAB held that the physician's report was not entitled to the special weight of the medical opinion evidence because it was based on an inaccurate statement of accepted facts.
See also A.C., Docket No. 07-2423 (issued May 15, 2008). ECAB held that the statement of accepted facts did not accurately reflect the conditions the OWCP accepted as employment related and, therefore, the physician's report was of diminished probative value and

insufficient to resolve the conflict in medical opinion.

Vague or generic terms such as light, heavy, undue, severe, irregular and abnormal are to be avoided, since they are subject to great differences of interpretation.

(5) Facts should be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. Use of legal terms and Government jargon should be avoided, since they are unfamiliar to external case reviewers. The SOAF should present a vivid picture of the circumstances of a claim so the reader will clearly understand them.

(6) Facts should be stated in a positive voice whenever possible. The CE should identify facts in terms of what can be verified, rather than what has not been, or cannot be, determined. For example, a SOAF should include specific language indicating "The employee lifted ten widgets," rather than "The employee lifted less than twenty widgets."

b. Length of SOAF. The length will vary depending on the issues to be resolved and the facts of the case. The test is whether the SOAF covers all material facts in sufficient detail to provide the physician with a complete picture of the claim without including superfluous information. There is no minimum length requirement except to include the items addressed under paragraph 5 below, "Essential Elements."

(1) In simple cases, a brief SOAF will usually suffice. For instance, where the only outstanding issue is determining a schedule award, the impairment is clearly related to the accepted injury, and there is no dispute concerning the medical evaluations for calculating the rating, the SOAF may be quite brief.

Note: In the case of a schedule award, all medical conditions or impairments to the schedule member should be listed and the instructions to the medical examiner should state that all impairments (preexisting, non-employment related and subsequently developed impairments) must be considered in calculating the award.

(2) In more complex cases, the SOAF will generally need to be longer so that the CE can fully address the pertinent facts. The SOAF may be multiple pages in length, although most issues can be adequately addressed in one page. SOAFs in a psychological/emotional claim are frequently longer due to the number and complexity of the issues raised in that type of claim.

c. SOAF Header. The header is centered at the top of the first page of the SOAF. The first line should state "Statement of Accepted Facts." The second line should include the claimant's name. The third line should identify the claimant's case number. The header font should be in all capital letters and in bold text.

If a SOAF is modified, the header should include, in bold, the additional line "This SOAF supersedes all prior SOAFs." (See paragraph 8 below regarding SOAF

modifications.)

d. SOAF Footer. The footer comes at the end of the SOAF body and consists of the author's name, title, and the date the SOAF was created or modified.

2-0809-5 Essential Elements

5. Essential Elements. For a physician to form a general impression of the individual or evidence to be evaluated, the CE must provide the following information in the SOAF:

a. Date of Injury -- allows the physician to estimate elapsed time and recovery.

b. Claimant's Date of Birth -- permits the physician to factor in any additional healing time if necessary.

c. Job Held on Date of Injury -- permits the physician to visualize the setting of the injury if it occurred during normal duties and possibly to make judgments about the claimant's potential for returning to duty.

d. Name of Employing Agency -- supplements information about the position held.

e. Employment history, including periods of wage loss and returns to full or light duty for the present claim -- helps put the employee's injury and work history in perspective. If the employee did not stop work, that should be reported.

f. Mechanism of Injury -- helps the physician to form an opinion on the relationship of the condition(s) diagnosed to the alleged injury and the severity or extent of the injury. In occupational illness cases, this information would include factors of employment and exposure data.

g. Condition(s) Claimed or Accepted -- allows the physician to assess whether the diagnoses provided in the medical evidence to be reviewed are consistent with the conditions for which the claim is filed or has been accepted.

h. In psychological/emotional stress claims, the CE will need to distinguish between those workplace activities and circumstances which are factors of employment and those which are outside the scope of employment for purposes of compensation. The CE must determine whether the situations alleged actually existed or occurred.

The CE should divide any SOAF containing both work-related and non-work-related elements into three parts, labeled as follows:

(1) Accepted Events that are Factors of Employment.

(2) Accepted Events that are Not Factors of Employment.

(3) Incidents Alleged which the Office Finds Did Not Occur.

Each incident should be numbered consecutively within the section to which it belongs.

ECAB has stated that such findings provide a proper frame of reference for the physician offering an opinion on causal relationship. See Abe E. Scott, 45 ECAB 164, 174 (1993), in which ECAB remanded the case for preparation of a SOAF addressing these factors.

2-0809-6 Optional Elements

6. Optional Elements.

a. Other elements may be included in the SOAF as described below, depending on the nature of the condition claimed and the issues to be resolved. Virtually all of them should be included when adjudicating an occupational illness claim, particularly where psychological/emotional stress is implicated.

(1) Prior medical history, including prior workers' compensation claims as appropriate.

(2) Medical treatment received, including initial medical treatment, surgeries, diagnostic testing and other relevant medical procedures, but the CE should not give a recitation of medical opinions or findings.

(3) Personal habits such as smoking or drinking, as relevant to the claim. While a smoking history would be particularly pertinent in an asbestosis claim, tobacco or alcohol use can affect many medical conditions.

(4) Concurrent medical condition(s), as potentially relevant to the claim. Pregnancy would be a relevant factor in a claim for carpal tunnel syndrome.

(5) Off-duty activities, employment and hobbies.

(6) Family circumstances and potential off-duty stress factors, as relevant to the claim, such as claims for psychological/emotional stress.

(7) A description of the claimant's work (mental, physical and environmental). However, a copy of the position description should not be used verbatim, since at best it will provide only general information or may be inaccurate or incomplete.

2-0809-7 Exclusions from SOAFs

7. Exclusions from SOAFs. Not all information contained in a case file bears on the issues to be resolved in connection with the SOAF. Some information is irrelevant, while other material is inappropriate, prejudicial, or better discussed elsewhere. The following items should not be included in the SOAF:

a. Evidence. Raw evidence, such as a police report or time card, should be not be attached or described verbatim in the SOAF. The CE is responsible for making decisions on raw evidence and incorporating the findings into the SOAF.

b. Justifications or Reasons for Conclusions Reached. The CE's findings should be supported by the evidence of record. Any explanation of the findings should be made in a memorandum to the file, not in the SOAF.

c. Medical Opinions. Such opinions should not, however, be confused with the medical history of the claim, which may properly be included. Chronologies of care and nature of treatment received are facts surrounding the medical aspects of a claim, but are not themselves medical opinions.

d. Payment of OWCP Compensation and OPM Annuities. An exception to this rule can be made in a psychological/emotional stress claim where the claimant has alleged to physicians that he or she is not receiving any income. Here the CE should state when benefits began and whether they continue or were terminated.

e. Issues for Determination. The SOAF is not used to outline the factual issues to be resolved. Factual issues belong in memoranda to the file. Medical issues to be resolved are properly addressed in a memorandum to the file or a letter to the physician.

f. Definitions of Terms. When a CE needs to define such terms as aggravation, precipitation or acceleration, he or she should do so in a letter to the physician along with the questions to be answered.

g. Discussion of Legal Issues. These should be discussed in a memorandum to the file.

h. Appeals and Administrative Actions. Histories of appeals, remands, and administrative actions of the OWCP, such as requests for investigations, do not help to resolve medical issues and may actually prejudice the outcome of a claim. An exception can be made in situations where a brief explanation would be useful in a long running case to note that the case has undergone multiple appeals or where ECAB has instructed that a new SOAF must be prepared.

2-0809-8 Modification of SOAF

8. Modification of SOAFs.

a. Modification of a SOAF is required whenever the previous SOAF ceases to accurately represent all current facts of a case record. It is important to note that modifying a prior SOAF is distinct from correcting an inaccurate SOAF. Updating factual or medical information would be a modification of a SOAF.

Correcting gross inaccuracies in a prior SOAF that may lead to a reduction of benefits, such as rescission of either a previously accepted condition or of an accepted case in its entirety, requires due process (notice and an opportunity to

respond) and a formal decision with appeal rights [see FECA PM 2-0804.17(k)].

Whenever the CE determines that a request to a physician is necessary to obtain a reasoned medical opinion on issues of causal relationship, such as the nature, extent and degree of a work-related condition, the CE will undertake a formal review of the case record. This review will be conducted in order to determine whether factual or medical changes have occurred since issuance of the previous SOAF. A physician's opinion would only be considered valid and be assigned the weight of medical evidence if that opinion was based upon an accurate factual and medical history. The CE, therefore, should consider amending a previous SOAF whenever further medical opinion is being sought.

b. There are certain instances when a CE must undertake modification of a SOAF. All modifications made to a SOAF must be supported by the evidence of record. Reasons for modifying a SOAF include, but are not limited to:

(1) A change in the work-related medical condition, where the evidence of record supports the acceptance of additional medical conditions.

(2) Rescission of a previously accepted medical condition when due process was given and a formal denial was issued.

(3) New information that reflects other changes in the claimant's life, such as a change in work duties or hours of work, or the claimant returns to any type of employment not previously noted in the SOAF.

(4) Receipt of an Investigative Memorandum which yields relevant findings not already known, such as a claimant regularly engaging in strenuous physical activity such as soccer games or operating a construction business.

c. Responsibility for modifying a SOAF rests solely with the CE. Neither the claimant nor the employing agency has an unqualified right under the Federal Employees' Compensation Act, its implementing regulations or procedures to approve or amend the SOAF.

Should an employing agency or claimant object to the content of a SOAF, they may submit additional evidence for the CE to review, but a CE is not required to modify a SOAF based upon an agency's or claimant's request.

Accordingly, while the CE may seek input or comment on a SOAF, the CE shall not obtain the approval of an outside party to the case in creating or modifying a SOAF. The CE alone is responsible for reviewing the case record for relevant changes in factual or medical evidence which warrant modification of the previous SOAF prior to obtaining additional medical opinion.

A claimant's disagreement with the SOAF is not a valid reason for refusing to attend an office-directed medical examination. See, V.H., Docket No. 07-1200 (issued

September 10, 2008), in which the appellant objected to the statement of accepted facts because it was over two years old. ECAB held that this was not a valid excuse to refuse to attend an impartial medical examination. If any adverse action were to arise from such an examination, the claimant may raise his or her objections during the appeals process.

d. If a SOAF should have been modified prior to requesting additional medical opinion but was either not modified or modified improperly and the SOAF contained a substantial error, the CE should amend the SOAF and request clarification from the physician who provided a report based on the inaccurate SOAF. The CE must specifically ask the physician for a reasoned medical opinion as to whether the modified SOAF affects the doctor's conclusions. Failure to return to the physician for clarification in this circumstance would diminish the probative value of that physician's opinion.

ECAB has ruled on the importance of ensuring that a SOAF accurately portrays the factual and medical aspects of the claim, remanding cases to the District Offices where the SOAFs were not current or accurate. In the case of Gwendolyn Merriweather, 50 ECAB 411 (Docket No. 97-2137, issued June 3, 1999), ECAB found that the referee examiner was not entitled to special weight because the doctor's opinion was not based upon a proper factual background. ECAB noted that OWCP made no findings as to whether the claimant had sustained a work-related aggravation of a preexisting condition and found that the SOAF was unclear. See also Liliana M. Martinez, 42 ECAB 517 (Docket No. 90-1944, issued March 20, 1991). ECAB found that the deficient factual background left the referee physician without a proper factual basis on which to form a medical opinion and ruled that this deficiency rendered that medical opinion of diminished probative value.

Exhibit1 - TI Sample

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JAMES JONES
FILE NUMBER: xxxxxxxxx

James Jones, date of birth 03/22/1975, is employed as a maintenance worker with the Department of Veterans Affairs. On April 14, 2009, he sustained an injury when a desk he was moving slid off a fork lift and slammed into his left knee, pinning his knee between the desk and a wall. He received initial medical attention at the Northwestern Medical Center on April 14, 2009.

The conditions of a left knee contusion and left knee sprain are accepted as causally related

to the April 14, 2009 employment injury.

A left knee arthroscopy was performed on September 10, 2009. Mr. Jones has not returned to work to date.

The duties of a maintenance worker require walking and standing for up to six hours per day; intermittent squatting, bending and kneeling for up two hours per day; pushing/pulling up to one hour per day; climbing stairs ½ hour per day; and occasional lifting up to 50 lbs.

Prior medical history: Claimant suffered a torn left knee medial meniscus as a result of a soccer injury at age 16.

CE Name
Title
Date

Exhibits 2-Basic OD Sample

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JANE DOE
FILE NUMBER: xxxxxxxxxx

Jane Doe, date of birth 04/06/1965, is employed by the US Department of the Treasury, Internal Revenue Service, as a Data Transcriber.

A Data Transcriber performs repetitive keyboard related tasks with an average keystroke of 7,500 to 8,500 per hour. In early May of 2008, Ms. Doe increased her keystrokes to 10,150 per hour and in so doing developed cramping in both hands and wrists. She subsequently developed numbness involving the 4th and 5th fingers of the right hand.

Ms. Doe stopped work on 05/18/08 and received initial medical attention on this dateat theMemorial Hospital emergency room. She returned to modified work on 05/19/08 performing keyboarding on a reduced 4 hour per day schedule. Effective 05/25/08, Ms. Doe came under the care of her family practitioner. She stopped work completely on 06/10/08.

The claim has been accepted for right ulnar nerve entrapment and left lateral epicondylitis as work-related.

On 06/27/2008, Ms. Doe underwent a right elbow ulnar nerve decompression and right elbow medial epicondylectomy, which were both accepted as work-related. She remains out of work following her surgery.

CE Name
Title
Date

Exhibits 3- Sample HL

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF JOHN JAMES
FILE NUMBER: xxxxxxxxx

Mr. James, date of birth 11/22/1954, was employed by the Department of the Army from July of 1985 until his retirement on June 1, 2009. His pre-employment physical on August 1, 1985 reported that he had normal hearing. During this timeframe, Mr. James held the following jobs; his occupational noise exposure for each position is summarized below:

September 7, 2003 to June 1, 2009 Mobile Equipment Repairer/Inspector

As a Mobile Equipment Repairer/Inspector, Mr. James was exposed to noise emanating from air tools, trucks and combat vehicles for approximately 2 hours per day. The dBA levels in the auto maintenance shop where he worked ranged from 84-104 dBA, with an average reading of 88 dBA. Mr. James wore ear muffs while working in the shop.

June 9, 1986 to September 6, 2003 Heavy Mobile Equipment Mechanic

As a Heavy Mobile Equipment Mechanic, Mr. James was exposed to noise emanating from air tools, trucks and combat vehicles for approximately 8-9 hours per day.
Decibel levels to which he was exposed ranged from 85 to 91.1 dBA. He wore ear plugs during this period.

October 27, 1985 to June 8, 1986 Warehouse Worker

As a warehouse worker, Mr. James was exposed to noise emanating from air tools and trucks for approximately 4-5 hours per day. He wore ear plugs while working in this capacity.

Non-Federal Employment History:

April 1983 to July 1985 Mechanic, Welder

Mr. James worked in the private sector in various capacities as both a mechanic and a welder. He was exposed to noise emanating from air tools, construction, and car and truck engines for approximately 4 to 12 hours per day. Ear plugs were used during this period for protection.

Hobbies:

Mr. James is an avid hunter and has been since the early 1970's. He began wearing earplugs for hearing protection in 1979. He is also a motorcyclist.

CE Name
Title
Date

Exhibits 4-EmotionalStress

STATEMENT OF ACCEPTED FACTS
IN THE CASE OF MARY SMITH
FILE NUMBER: xxxxxxxxx

Ms. Smith, date of birth 11/27/1972, is employed by the US Postal Service as a PTF (part-time flexible) Letter Carrier in Anytown, USA; she has worked as a PTF Letter Carrier since June of 2000. On 08/30/09, she filed a notice of occupational disease due to emotional stress. She initially sought treatment from _____, M.D. and has since transferred her care to _____ , PhD. She stopped work on 08/30/09 and remains out of work.

Federal workers' compensation law does not apply to each and every illness that is somehow related to employment. Therefore, we have to differentiate between employment events that are considered to be related to the employee's duties; those that are somehow related to the employment, but are not directly related to his/her duties; and allegations that have not been established. This Statement of Accepted Facts outlines these three categories.

I. Accepted Event(s) That Are Factors of Employment:

1. On May 9, 2009, Ms. Smith was told by a supervisor to throw bulk mail for a male co-worker because he was lagging behind. The co-worker told Ms. Smith she was throwing the mail too fast and needed to slow down. She continued to work at a fast pace and the co-worker got angry and began to throw the newspapers and magazines at her legs.

2. Several letter carriers were out from June 1, 2009 to August 20, 2009. This increased her daily workload, requiring that she work 50 -60 hours per week.

3. On August 21, 2009, a co-worker yelled and swore at Ms. Smith, accusing her of making all the other carriers look bad by sorting her mail in advance of everyone else. This same co-worker warned Ms. Smith to watch her back, adding "I know where you live."

II. Accepted Event(s) That Are Not Factors of Employment:

1. On August 25, 2009, Ms. Smith was assigned to a different post office. This re-assignment added an additional hour to her commute and created conflicts with child care arrangements.

2. Ms. Smith was dissatisfied with her new delivery route and considered it less desirable than her previous route.

III. Incident Alleged Which the Office Finds Did Not Occur:

Ms. Smith alleged she was physically assaulted by her supervisor in a December 3, 2008 meeting where two other witnesses attending the meeting said that the supervisor did not touch Ms. Smith.

CE
Title
Date

2-0810 DEVELOPING AND EVALUATING MEDICAL EVIDENCE

TABLE OF CONTENTS

***ENTIRE CHAPTER REISSUED 09/10, TRANSMITTAL 10-10**

2-0810-1 Purpose and Scope

1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE's) function in evaluating medical evidence and authorizing treatment. FECA PM Part 3, Medical, also contains useful chapters relating to medical issues and should be consulted.

2-0810-2 Introduction

2. Introduction. The CE is responsible for obtaining the appropriate type of medical evidence, evaluating it, and weighing it to resolve inconsistencies and conflicts in medical opinions. This chapter defines and discusses the terms and procedures involved in the weighing process and provides examples of common situations in accepted disability cases where medical development is needed and guidelines for determining the weight of medical evidence.

2-0810-3 Important Principles in Reviewing Medical Evidence

3. Important Principles in Reviewing Medical Evidence.

a. Once the OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After the OWCP has determined that a claimant has disability causally related to his or her employment, the OWCP may not terminate compensation without establishing that the disability has ceased or is no longer related to the employment. [Kathryn E. DeMarsh, 56 ECAB 677 (2005); Robert R. Henderson, 30 ECAB 549 (1979)]

b. Resolving the issue of whether disability has lessened or ceased, or is no longer causally related to the employment, rests primarily within the realm of the medical expert. [Eloise L. Berry, 25 ECAB 61 (1973)] This is why development and weighing of medical evidence are both so important in accepted disability cases. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken and in assigning weight to the medical evidence received.

c. When evaluating medical evidence to substantiate causal relationship, both during the adjudication process and then later during medical management, the following concepts should be considered.

(1) Aggravation occurs if a pre-existing condition is worsened, either temporarily or permanently, by an injury arising in the course of employment.

(2) Temporary aggravation involves a limited period of medical treatment and/or disability, after which the employee returns to his/her previous physical status.

(3) Permanent aggravation occurs when a condition will persist indefinitely due to the effects of the employment related injury, or when a condition is materially worsened such that it will not revert to its previous level of severity. In order to establish that permanent aggravation has occurred in a physical disability case, there should be objective evidence of a physiological change in the claimant's pre-existing condition.

(4) Acceleration occurs when an employment-related injury or illness hastens the development of an underlying condition and the ordinary course of the disease does not account for the speed with which a condition develops.

(5) Precipitation means that a latent condition, which would not have become manifest but for the employment, occurs. Similar to a temporary aggravation, any ensuing episode of the disease would be considered work-related only if medical evidence supported such a continued relationship.

2-0810-4 Sources of Medical Evidence

4. Sources of Medical Evidence. This paragraph describes some of the usual sources of medical evidence likely to be found in a case file.

a. While this list is not exhaustive, most medical evidence will fall into one of the following categories.

Attending Physician (AP). The claimant's AP is the primary source of medical evidence in most cases. That physician usually sees the claimant soon after the injury or the onset of symptoms. He or she may also be familiar with the claimant's medical history and therefore may know of any pre-existing condition which may be responsible for the symptoms, or which may have been aggravated by the incident or employment factor claimed.

District Medical Advisor (DMA). The DMA furnishes opinions, guidance and advice based upon review of the case file and familiarity with FECA requirements.

Second Opinion Specialist. At the request of the OWCP, a second opinion physician provides examination, indicated diagnostic testing, and rationalized medical opinion when a detailed, comprehensive report and opinion is needed from a specialist in the appropriate field.

Referee Specialist. Where the medical reports from the claimant and the medical reports from the OWCP-designated physician(s) are of equal but opposing value, 5 U.S.C. 8123(a) of the Act, as interpreted by the ECAB, requires an examination by a third physician who is termed a referee or impartial specialist. The referee or impartial specialist examines the claimant, arranges diagnostic tests, and furnishes rationalized medical opinion to resolve a conflict or disagreement between a claimant's physician and a physician designated by the OWCP (the DMA or a second opinion specialist) where the weight of medical evidence is equally balanced.

Clinical Psychologist. A clinical psychologist is considered a physician under section 8101(2) of the Act within the scope of his or her practice as defined by state law. The following criteria must be met: the individual is licensed or certified as a psychologist at the independent practice level of psychology by the state in which he or she practices; either possesses a doctoral degree in psychology from an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation or is listed in a national register of health service providers in psychology which the Secretary of the Department of Labor deems appropriate; and possesses two years of supervised experience in health service, at least one year of which is post degree. See PM 3-100.

Chiropractor. Under section 8101(2) of the FECA, chiropractors are recognized as physicians only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

Hospital or Emergency Facility. Hospital in-patient reports, such as the admission history and physician examination, the doctors' progress notes and the discharge summary, along with emergency and out-patient reports, are frequently valuable in documenting the time of injury and associated factual circumstances bearing on work-relatedness (from the date and time of admission and the history recorded), the nature and extent of injury, and the duration of disability anticipated.

Diagnostic Test Results. These include reports of x-rays, computerized axial tomography (CAT), magnetic resonance imaging (MRI), electrocardiograms (ECG or EKG), electroencephalograms (EEG), electromyograms (EMG), audiograms, treadmill stress tests, cardiac catheterization, intravenous pyelograms, and similar techniques of visualizing or recording physiological conditions.

Therapy Reports. While not useful for making adjudicatory or medical determinations in a case, therapy reports from physical and occupational therapy are useful for documenting treatment for a work related condition. See Jennifer L. Sharp, 48 ECAB 209 (1996) (physical therapists are not physicians as defined under the FECA; their reports, therefore, do not constitute competent medical evidence to support a claim).

Nurse Practitioner or Physician's Assistant. Treatment by an advanced practice nurse or a physician's assistant is payable as a medical expense under 5 U.S.C. 8103 of the Act. However, a report from an advanced practice nurse or a physician's assistant is not competent medical evidence to support a diagnosis, disability or need for additional medical treatment unless the report is co-signed by a physician.

Fitness for Duty Examinations Directed by the Employing Agency. A report from such a physician should receive due consideration; however, since the agency directed the examination, reliance upon the findings for case action must be tempered. If the findings or conclusions differ materially from those of the AP, the CE may consider further development, but the reports cannot be used as the basis for a formal reduction or termination of benefits. Also, under FECA procedures, such a report may not be used to create a conflict in medical evidence that requires resolution under 5 U.S.C. 8123(a).

b. Occasionally, other documentation is submitted to support a medical condition or causal relationship in a case, but it not considered to have any evidentiary value.

Internet articles, medical texts and excerpts from publications. These are of no value in establishing the necessary causal relationship between a claimed condition and employment factors because such materials are of general application and are not determinative of whether the specifically claimed condition is related to the particular employment factors alleged by the employee. See Dominic E. Coppo, 44 ECAB 484 (1993).

Findings of other agencies (such as the Social Security Administration or the Department of Veterans' Affairs). The ECAB has held that findings of other government agencies are not dispositive with regard to questions of disability arising

under the FECA. See Dona M. Mahurin, 54 ECAB 309 (2003) and Daniel Deparini, 44 ECAB 657 (1993).

Evaluations from Social Workers. Social workers are not considered to be physicians under the Act. See Debbie J. Hobbs, 43 ECAB 135 (1991) and Jacqueline M. Johnson, Docket No. 98-2450 (issued March 9, 2000).

2-0810-5 Content of a Medical Report

5. Content of a Medical Report. A medical report should ordinarily contain:

a. History. A medical opinion is only as good as the "frame of reference" on which it is based. It should be based on an adequate factual and medical background. In other words, the record should show whether the history obtained by the physician is substantially in accord with the facts of the accident or accepted employment conditions. For example, if the physician provides a history of sharp pain upon twisting the right knee when stepping from a curb and diagnoses a torn medial meniscus resulting from the twisting event, the medical opinion expressed is of diminished value if the facts surrounding the claim do not involve a twisting component but rather the sudden onset of pain while walking on even ground. Or, if a physician simply refers to the claimant having sustained an injury at work without identifying the cause or mechanism of injury, the physician's opinion relating a condition to an injury at work lacks probative value as there is no indication that the physician is basing the opinion on an accurate history.

However, sound judgment must be applied. For instance, if Form CA-1 shows concurrence of the employer with a report of an ankle injury due to falling off a ladder, and this history is repeated in the emergency room report of treatment soon after the time of injury, there is no need to question a subsequent report which fails to record the specific history.

b. Findings. The scope of findings needed in a case will vary based on the type of medical problem and the complexity of the case. Only minimal findings need to be reported for a traumatic amputation of a finger, but the physician should be required to set forth a detailed account of the findings where the nature of injury, causal relationship to employment, or extent of disability is not so apparent.

The three general classes of findings are:

(1) Physical findings, which are noted by the physician's visual inspection, palpation and manipulation of the body. They include readings of temperature, pulse, respiration, blood pressure, range of motion, etc.

(2) Laboratory findings such as blood tests, urine and tissue samples, etc.

(3) Reports of a diagnostic procedure, such as an x-rays, MRI, EMG, etc.

Tests requiring cooperation by the patient, such as visual, hearing and pulmonary function tests, may be accompanied by a comment from the person administering the test regarding the extent of the patient's cooperation and the validity of the results. If a tester indicates that the patient exhibits poor effort or did not cooperate with testing in conjunction with a medical examination, a concerted lack of cooperation may be considered obstruction of a medical examination under 5 U.S.C. 8123(d). See paragraph 13 in this chapter.

To be acceptable as medical evidence, a laboratory test or diagnostic procedure should be performed by, or under the supervision of, a person licensed to perform it in the state or local jurisdiction where it was done. Reports of such tests and procedures should contain the patient's name, date of the test, the objective data obtained, and the name of the person responsible for performance of the test or procedure.

Where appropriate, reports should include the physician's interpretation of laboratory tests and diagnostic procedures. Tests for which such interpretation is necessary include, but are not limited to, x-rays, EKGs, EEGs, EMGs, MRIs, CAT scans, cardiac and pulmonary stress tests, pulmonary function tests, biopsy or surgical specimen pathology reports, ultrasound, visual field, echo cardiograms and intravenous pyelograms.

c. Medical Opinion with Rationale.

(1) Not all medical opinions require detailed rationale. In a simple traumatic injury such as slip or fall which is reported to and seen by the physician promptly, there is no need to obtain a “rationalized” explanation of causal relationship.

(2) When causal relationship is not obvious or when there may have been an intervening non-occupational cause, it is essential that the physician give his or her medical reasons for relating the condition to the history obtained. A rationalized opinion is also necessary, and should be requested, when disability appears to last beyond the time frame anticipated for an injury of the type accepted.

(3) A medical opinion couched in such terms as "might be," "could be," or "may be" does not have as much probative value as an opinion stated unequivocally or with reasonable medical certainty.

2-0810-6 Weighing Medical Evidence

6. Weighing Medical Evidence. Weighing is the process of evaluating medical opinions to determine which has more probative value. When medical evidence is present from more than one source, as in most cases, this process consists of determining the relative value, or merit, of each medical opinion.

a. When evaluating the merit of a medical report, the ECAB has repeatedly stressed the importance of certain criteria. Based on these criteria, the CE should ask the following questions with regard to each report when weighing medical evidence:

(1) Is the opinion based on a complete, accurate, and consistent history covering both the medical and factual aspects of the case?

A medical opinion that takes into account the claimant's medical history, the relevant family medical history, non-work factors that could have led to the injury or disease, and a complete and consistent history of the incident or exposure or work factors alleged to be the cause of the injury or illness carries more weight than an opinion that has omissions, errors or inconsistencies in any of these areas.

For example, a physician may indicate that a torn cartilage is due to a work-related fall, in a situation where 10 days earlier the employee had developed knee pain after playing basketball off the job. In this situation, the physician's opinion relating the cartilage tear to the work injury, even with a medical explanation, will not have weight if the physician failed to note and discuss the pertinent history and the recent basketball incident.

An incomplete or inaccurate history reduces the probative value of a medical opinion. The lack of any history in a report also usually diminishes the value of the report. See Donney T. Drennon-Gala, 56 ECAB 469 (2005) (The ECAB held that the Board-certified psychiatrist's opinion was of diminished probative value as the report provided no history of any specific employment factors). When two physicians give reasoned but differing opinions concerning causal relationship and one physician's opinion is based on an inaccurate or incomplete factual or medical background, the opinion based on an accurate factual or medical history typically has more probative value. See Floyd Stilley, Docket No. 02-2016 (issued February 19, 2003) (The claimant's attending physician based his opinion on an inaccurate history, while the Office referral physician based his opinion on a thorough review of the factual and medical evidence of record, an accurate history of injury, and the results of objective testing. The ECAB held the weight of the medical opinion rested with the Office referral physician).

(2) Is the opinion well-reasoned and well-rationalized?

A rationalized opinion is of greater probative value than an opinion which is

not rationalized. The physician should generally explain the basis for the opinion. This is of particular importance where the question involves a difficult medical problem, or where there is conflicting opinion. A medical opinion consisting solely of a conclusive statement regarding disability, without supporting rationale, is of little probative value.

The terms "reasoned" or "rationalized" mean that the statements of the physician are supported by a medical explanation. In some situations, no explanation is required. For example, when an injury is incurred during the performance of duty, the claimant obtains prompt medical care, and the mechanism of injury is clearly sufficient to cause the claimed condition (e.g., a cervical sprain from a rear-end motor vehicle collision), a simple affirmative answer by the physician on the issue of causal relationship may suffice.

In most cases, however, medical rationale will be required. An occupational disease case or a traumatic injury case with pre-existing or subsequent injury to the same part of the body will require, in addition to the physician's affirmative opinion, an explanation of the causes of the condition claimed and a discussion of these factors in relation to the claimant's condition. This explanation and discussion are what constitute medical "reasoning" or "rationale." Sufficient objective data (findings on examination, test results, etc.) should be present so that a reviewer can determine on what specific evidence the medical conclusions were based.

A well-reasoned medical opinion should also be consistent with the findings upon examination. Findings may be noted during physical examination, laboratory testing, and diagnostic procedures. Sufficient objective data (findings on examination, test results) should be included in the report to support the medical conclusions. For example, a physician might state that a claimant has a back sprain causally related to a work injury that occurred ten years ago, without citing physical findings to support this conclusion. The physician explains that the claimant's injury is causally related to the past injury because prior to the incident the claimant had no complaints of back pain, whereas since the injury the claimant has continued to complain of back pain. An explanation such as this, not supported by physical findings, will not constitute a well-rationalized medical opinion.

A well-reasoned medical report sometimes contains citations from medical reference sources and other information to support the opinion.

(3) Does the physician have the expertise and credentials to provide medical opinion in this case?

The ECAB has held that a physician's qualifications may have a bearing on the probative value of his or her opinion. The opinions of physicians who have training and experience in a specialized medical field have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians. See Lee R. Newberry, 34 ECAB 1294, 1299 (1983). Thus,

the opinion of a specialist in the appropriate field of medicine often will carry more weight than the opinion of a non-specialist or a specialist in an unrelated field.

Various medical specialty boards exist, including the American Osteopathic Association (see PM 3-0500-7). Each Board conducts a certification program in an effort to ensure quality of medical services by adherence to standards of medical training and practice in the specialty. Although any licensed physician may limit his or her practice to a certain specialty, a Board-certified specialist has met the minimum standards of training and competency in the field as set by the Board. Some medical boards also award certifications in subspecialties. For instance, a physician certified by the American Board of Internal Medicine may also be certified in a subspecialty such as cardiology. Board certification should not, however, be confused with Board eligibility, which means that a physician has completed the educational requirements for taking certification examinations but confers no special status.

The opinion of a Board-certified specialist in the appropriate field will usually carry more weight than that of a specialist who is not Board-certified or who is certified in an unrelated field. The opinion of a Board-certified specialist of professorial rank in a medical school or teaching hospital, or of a specialist who is an acknowledged expert or author on the specific medical problem, may carry added weight.

(4) Does the physician have enough knowledge about the employee to have arrived at a sound medical opinion?

A comprehensive report is one which reflects that all testing and analysis necessary to support the physician's final conclusions were performed. Generally, greater probative value is given to a medical opinion based on an actual examination. An opinion based on a cursory or incomplete examination will have less value compared to an opinion based on a more complete evaluation. The ECAB has remanded cases where a physician has indicated that further testing or evaluation is necessary to resolve an issue and the OWCP has not arranged for the required testing or evaluation. See Glenn P. Buckmann, Docket no. 96-356 (issued December 5, 1997).

Other things being equal, the probative value of an opinion increases when the physician reports specific detailed findings, based on a full and careful physical examination, x-ray studies, and appropriate laboratory and clinical tests. Opinions not supported by medical findings, or otherwise indicative of cursory examinations, carry little weight compared to opinions based on detailed examinations and findings. Furthermore, the opinions and conclusions reached by the physician should be consistent with the examination and test results.

In cases where the medical issue is the current extent of disability, the well-reasoned opinion of a well-qualified specialist who examined the claimant

only once can weigh as heavily as, or even heavier than, that of a non-specialist who has seen the claimant regularly over time. If the specialist was provided with the appropriate medical records contained in the case as well as the Statement of Accepted Facts (SOAF), he or she will have a sufficient history to render a well-reasoned opinion regarding the extent of disability following his or her examination of the claimant.

(5) Is the medical opinion speculative or equivocal?

Medical opinions which are speculative or equivocal in character have little probative value. Opinions which can be characterized as equivocal, speculative or conjectural are those which contain language which is unclear or vague. Terms such as "could," "may," or "might be" indicate that the report is equivocal, speculative or conjectural and has less probative value compared to a positively expressed medical opinion.

The terms "probably" and "most likely" are less speculative and should be viewed in the context of the rest of the medical report and the factual evidence, since sometimes this could mean that the physician is expressing an opinion based on reasonable medical certainty, as opposed to absolute certainty. If the physician's meaning is in question, he or she should be asked to explain the basis for any doubt and to state with reasonable certainty whether or not the disability is related to employment.

b. After these criteria have been considered, the CE must determine to his or her satisfaction the merit of each opinion. The value of the evidence cannot be established by making a "checklist" or counting the "pros" and "cons" for each criterion. No individual factor standing alone necessarily determines the weight of medical evidence. Medical evidence is weighed on a case by case basis considering the specific evidence needed to resolve the medical issues in that particular case.

c. An example of weighing, in which two reports are submitted and both reports are from Board-certified orthopedists. Both physicians provided well-rationalized reports based on an accurate medical and factual background; however, they offer differing opinions regarding the extent of the claimant's disability. Although both physicians examined the claimant, one physician performed current diagnostic testing and referred the claimant for a functional capacity evaluation. Therefore, this physician was able to provide his opinion based upon the most current test results and findings. Based on the overall comparison of the reports, they may be equal in many aspects but the weight can be afforded to the physician who provided hisreasoned opinion based upon the most current test results pertinent to the issue under review.

d. Weighing Medical Evidence in Formal Decisions. Section 8124 of the FECA provides that a finding of fact shall be made in determining an award for or against payment of compensation. Decisions that are based on medical evidence should contain an analysis of the relative merits of the pertinent medical evidence of record as it relates to the issue for determination in the decision. Weighing is a part of this

process if conflicting reports are on file. This means that the CE should not only state that a particular piece of medical evidence constitutes the weight of that evidence, but also give the reasons for assigning that weight. For example:

(1) In a case where continuing benefits are denied on the basis of a report from a second opinion specialist, the CE may note that the second opinion specialist was Board-certified in the appropriate field of medicine, performed a full and complete evaluation, reviewed a current SOAF, and provided a rationalized medical opinion. The CE would contrast the second opinion report with the report of an AP, finding that the AP's supportive opinion on continuing disability was of diminished probative value compared to that of the second opinion physician, since the AP was not a specialist and did not provide detailed reasoning in support of his or her opinion. A CE should use discretion when finding that the weight of medical opinion rests with the second opinion examiner over the AP.

(2) In a case where a referee (impartial) medical evaluation was sought to resolve a true conflict in medical opinion, the explanation should identify the physicians whose reports are in conflict and the issue of disagreement, and may include reference to the provisions of 5 U.S.C. 8123(a) pursuant to which the referral to the impartial specialist was made. The CE may then make the finding that because the opinion was thorough, unequivocal, rationalized and prepared by an appropriate Board-certified specialist, it should be afforded special weight. See James P. Roberts 31 ECAB 1010 (1980); R.C., 58 ECAB 238 (2006).

2-0810-7 Requesting Information from the Attending Physician (AP)

7. Requesting Information from the Attending Physician (AP). In all cases of serious injury or disease requiring hospital treatment or prolonged care, the CE should request detailed narrative reports from the AP at periodic intervals. The AP "will be asked to describe continuing medical treatment for the condition accepted by the OWCP, a prognosis, a description of work limitations, if any, and the physician's opinion as to the continuing causal relationship between the employee's condition and factors of his or her Federal employment." 20 CFR §10.332

a. The AP will be a primary source of contact for medical updates. At regular intervals, the AP should provide medical updates addressing the claimant's current condition and medical status, continuing causal relationship of the condition to employment, treatment plans, projected healing times, and work restrictions. Non-receipt of regular updates should usually prompt development for such information from the CE.

b. A request for medical information from the AP may be the most efficient and expeditious means to obtain a medical status update and address any unresolved medical issues. The CE must ensure, however, that the AP's reply is well-reasoned and responsive to the questions asked. The quality of AP reports will vary greatly. Sometimes reports are lacking in detail because the physician is unaware of the type of information required to meet OWCP standards in a given case. If reports from the AP lack needed details and opinion, or if the subjective complaints and time loss from work appear inconsistent with the objective findings and the claimant's diagnosis, the CE can write back to the physician, clearly state what is needed, and request a supplemental report. Development for a schedule award may also prompt an inquiry to the AP regarding the extent of permanent impairment and date of maximum medical improvement.

A copy of the CE's request to the physician should be sent to the claimant for informational purposes.

c. If a Field Nurse (FN) is involved in the case, the CE may confer with the nurse regarding specific questions to be asked, and may also ask the nurse to contact the AP to obtain the necessary information.

d. The lack of a well-reasoned or fully responsive reply may suggest that a referral to a DMA for clarification or a second opinion examination is warranted.

e. The time allowed for the AP's reply should be carefully monitored. If the reply is not received within the specified time frame (usually 30-45 days), or if the reply is equivocal, the CE should consider a second opinion.

2-0810-8 Reviews by a District Medical Advisor (DMA)

8. Reviews by a District Medical Advisor (DMA).

a. The DMA's primary medical functions are evaluating medical evidence and interpreting physician reports. The CE seeks evaluation from the DMA in order to proceed with developing and weighing the medical evidence. The CE seeks interpretation from the DMA only where the medical evidence is complete and sufficient prior to such review. In either case, the comments or opinions of the DMA should be explained or rationalized.

b. The DMA's performance of these functions does not lessen the CE's responsibility in case management. The CE must always maintain responsibility for the case and should not consult the DMA to adjudicate claims or determine benefit entitlement, as these are primary functions of the CE.

c. The DMA has no authority to decide the facts in a case, as this is a function of the CE. However, the DMA may state whether an accepted incident was competent to produce the injury claimed. The DMA should be presented with the correct factual framework for the medical opinion requested. A SOAF is often the best avenue for conveying this information. Where the DMA finds that a determination pertinent to the medical opinion has been omitted, he or she should inform the CE of the additional factual information needed to place the case in posture for a rationalized medical opinion.

When referring a case to the DMA, the CE should submit medical questions which are case and issue specific.

d. The CE must utilize the DMA in the following circumstances:

(1) The CE is adjudicating a schedule award claim and requires a calculation of the percentage of impairment in order to establish the schedule award.

(2) The AP has requested authorization to perform a significant elective surgery (e.g., organ transplant, spinal surgery, joint replacement, chordotomy, rhizotomy, amputation, etc.). The CE may also refer the case to a second opinion specialist to determine whether the requested surgery should be approved. See Paragraph 10.

e. The CE may utilize the DMA in the medical management of a case in the following circumstances:

(1) The CE is uncertain about the accuracy of the AP's medical opinion, diagnosis of injury, or medical rationale. The CE may request the opinion of the DMA to determine whether the DMA agrees with the AP's opinion or deems it questionable.

(2) The AP certifies continuing disability without objective medical findings

or sufficient rationale, and the CE believes that the physician's opinion may be unreasonable.

(3) The AP does not provide the CE an estimate of how long disability will continue. The CE may ask the DMA about the probable duration of disability in order to determine the next appropriate case management action.

(4) If the CE needs advice on unfamiliar or technical medical issues, the CE may ask the DMA to clarify those issues. For example, the CE may ask the DMA to discuss whether the tests performed by the physician are appropriate and whether the test results support the physician's opinion.

It must be noted that the DMA should be used only when the CE truly needs medical guidance to interpret the reports in file or to clarify a medical issue. If the CE can determine on his or her own that a discrepancy exists between the reported disability status and the physical findings, or between the nature of injury and the degree/duration of reported disability, other CE action may be appropriate (e.g., writing to the AP, arranging for a second opinion evaluation, etc.).

f. The ECAB has affirmed that a DMA may create a conflict in medical opinion necessitating a referee medical evaluation under the provisions of 5 U.S.C. 8123(a). See Harold Travis, 30 ECAB 1071 (1979). However, the CE should exercise discretion when concluding that the DMA opinion creates a conflict in medical opinion with the AP.

In order for the value of the referee opinion to be enhanced and based on an actual conflict in medical opinion, the referee should receive a DMA report containing a well-reasoned opinion of equal weight to the AP opinion that actually creates a conflict in medical opinion. For example, when asked whether work-related disability continues, the DMA's unexplained response "no" is not sufficient to create a conflict in medical opinion. In order for the DMA's opinion to be of equal weight with the treating physician's opinion and create an actual conflict, the DMA's opinion should be rationalized and based on a complete and accurate factual and medical history.

g. While the DMA may create a conflict in medical opinion, the DMA may not resolve it. Furthermore, the DMA's reasoned medical opinion will not usually constitute the weight of the medical evidence in an accepted disability case, even if the DMA is a Board-certified specialist in the appropriate field of medicine and the AP is not a specialist and offers no rationale, because the DMA has not examined the claimant and the AP has a critical function in determining extent and duration of injury-related disability.

h. The DMA may provide an opinion which is not strong enough to constitute a conflict with the opinion of the treating physician but which is nevertheless of sufficient value to warrant additional action. For instance, where an AP states that a claimant is still disabled from a work-related back strain six months post-injury, the DMA may state that a two-month recovery period should have been sufficient. In

this instance, referral for a second opinion examination would be appropriate.

i. In a claim for a schedule award, if the medical evidence of record indicates maximum medical improvement has been reached and describes the permanent partial impairment of the affected member in accordance with the current edition of the AMA Guides to the Evaluation of Permanent Impairment, the case should be referred to the DMA for review.

The DMA should review the report to verify correct application of the AMA Guides and confirm the percentage of permanent impairment and the date maximum improvement was reached. The DMA should specify his or her reasons for assigning a certain percentage of loss of use to the measurements or factors provided. If the medical evidence does not contain the required elements for a schedule award impairment calculation, the CE should request such information from the AP prior to a DMA review. If the AP does not submit the requested information, the CE should obtain the evidence through a second opinion evaluation prior to a DMA review.

j. The DMA's opinion may constitute the weight of medical opinion in schedule award cases. If an opinion on the percentage of permanent impairment and a description of physical findings is on file from an examining physician, but the percentage estimate by this physician is not based on the AMA Guides, an opinion by the DMA which gives a percentage based on reported findings and the AMA Guides may constitute the weight of the medical evidence.

As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA Guides, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The CE must ensure, however, that the DMA properly considers all reported findings, gives rationale, and uses the AMA Guides correctly in computing the percentage. The DMA should also explain any difference between his or her findings and the findings of the AP report upon which the DMA is basing his or her opinion. This is necessary to determine whether weight can be assigned to the DMA or whether a conflict of medical opinion exists.

If the AP misapplied the AMA Guides, no conflict would exist because the AP report would have diminished probative value and the DMA's opinion would constitute the weight of medical opinion. However, if the DMA and the AP disagreed on, for instance, the level of impairment in a sliding scale, this could constitute a conflict of medical opinion.

k. If a case has been referred for a referee evaluation to resolve the issue of permanent impairment, it is appropriate for the DMA to review the calculations to ensure the referee physician appropriately used the AMA Guides. However, the ECAB has held that while an Office medical advisor may review the opinion of a referee specialist in a schedule award case, the resolution of the conflict is the specialist's responsibility. The DMA cannot resolve a conflict in medical opinion. If necessary, clarification to the referee examiner may be needed. See Richard R. Lemay, 56 ECAB 341 (2005).

Also, where a referee examination is arranged to resolve a conflict created between a claimant's physician and an Office DMA with respect to a schedule award issue, the same DMA should not review the referee's report for proper application of the AMA Guides.

2-0810-9 Second Opinion Examinations

9. Second Opinion Examinations.

a. The decision to refer a case for a second opinion examination rests with the CE, though such an exam may be recommended by a FN or DMA, or requested by the employing agency. A fitness for duty examination directed by the employing agency may not be considered a second opinion examination; however, if the findings or conclusions of such an exam differ materially from those of the AP, the CE may consider a second opinion referral.

A second opinion specialist should be selected who is administratively qualified, as discussed in FECA PM 3-0500. Second opinion examinations are generally conducted by a physician selected by a medical referral group that has contracted with the OWCP to provide second opinion medical referrals. The methods for selecting second opinion physicians are more flexible, since a strict rotation of physicians is not required for this type of examination.

The second opinion specialist should generally be provided with a SOAF, a list of pertinent questions or issues to be addressed, and copies of pertinent medical reports from the case record.

b. The CE should refer a claim to a second opinion specialist in the following circumstances:

(1) The CE has gathered all the medical information and evidence from the AP and does not have enough evidence about a diagnosis or an adequately reasoned opinion about causal relationship to accept the case, but does have sufficient evidence to suggest that the claimant might be entitled to benefits.

(2) The AP's examinations and reports in occupational disease cases do not provide the specific evidence that the OWCP requires for adjudication. The primary examples include hearing loss and asbestosis claims requiring examination in compliance with the specifications outlined in FECA PM 3-0600, or an emotional injury case where a compensable factor of employment is identified.

(3) Temporary total disability (TTD) has gone on longer than usual in a case, and the AP is not an appropriate specialist or has not satisfactorily explained the reason for the continued disability or why the disability is causally related to the original work injury.

(4) The CE has reason to believe that a claimant is no longer disabled due to the accepted work injury, or no longer has objective residuals of the accepted injury, but the AP maintains that the claimant has residuals or disability from the work injury and does not submit sufficient medical rationale to support that opinion.

(5) The AP cannot or will not send an acceptable permanent impairment evaluation based on the AMA Guides. If the AP has submitted an examination report which outlines medical findings and calculates a percentage of impairment based on the appropriate version of the AMA Guides, the CE should submit the AP's report to the DMA for the schedule award calculation and forego referring the claimant to a second opinion specialist for the same purpose.

(6) Following a consult or referral with the DMA, the DMA indicates that the file does not contain sufficient medical evidence to make a decision on the medical issue or provide a rating of impairment. In such cases, the DMA may recommend referring the case to a second opinion specialist.

c. The second opinion examination should constitute a complete evaluation of the claimant. The specialist should be asked to submit a report which includes a history of injury, a description of objective findings found on examination, the claimant's subjective complaints, and the results of diagnostic tests. Depending on the circumstances of the case, the specialist may also be asked to provide identification of any underlying or pre-existing condition(s); a diagnosis; a prognosis; the recommended course of treatment to be followed; any medically warranted restrictions or limitations (using Form OWCP-5); discussion of whether the work restrictions are due to work-related or non-industrial condition(s); a clinical estimate of the date of partial and/or full recovery; and/or a rationalized opinion on whether the claimant has objective residuals and/or disability from the work-related condition. Any other specific issues raised by the CE should also be addressed.

d. If the case has not yet been accepted and causal relationship is at issue, the specialist should be asked for an opinion with medical rationale which confirms or negates a causal relationship between any condition found and the accepted incident or accepted factors of employment. The specialist should be instructed to use the SOAF as the factual background for the accepted employment incident or factors.

e. In cases involving a pre-existing or underlying condition, the specialist should be asked to provide a rationalized opinion as to whether the pre-existing or underlying condition was aggravated by the employment incident or factors and, if so, whether the aggravation was temporary or permanent. If temporary, the specialist should also state when the aggravation ceased or can be expected to cease. Depending on the case, acceleration or precipitation may also be at issue. See paragraph 3 in this chapter for an explanation of these terms.

f. The information described above should give the CE a clear picture of the nature and extent of the claimant's disability and its relationship to the accepted condition(s). It should also allow the CE to determine the next logical intervention in the case.

g. If a surveillance video of a claimant has been submitted by the employing agency (EA) or an investigative agency, and the CE has determined that this

evidence should be incorporated as part of the case record and is germane to issues being addressed by the second opinion specialist, the CE should direct the specialist to review the video evidence and reference it in his or her report. Should the video evidence be submitted directly to the specialist prior to CE review, the CE should request a copy of the video from the EA; if the EA does not provide the video to the OWCP, the CE should direct the specialist to disregard the video evidence.

Once a surveillance video is provided to the OWCP with a request that it be used in the management of the case, it becomes part of the official case record and a copy will be released to the claimant, if he or she requests it, just like any other portion of the case record. The ECAB held in J.M., 58 ECAB 478 (2007), that the OWCP has the responsibility to make the claimant aware that it is providing surveillance video evidence to a medical expert. If the claimant requests a copy of the surveillance video, one should be made available, and the claimant given a reasonable opportunity to offer any comment or explanation regarding the accuracy of the recording.

h. The CE should not generally refer second opinion examination reports to the DMA for review unless the DMA is calculating a schedule award and requires the report to determine the impairment rating. A second opinion report may also be referred to the DMA by the CE if guidance is needed with regard to a specific medical issue.

i. The findings or opinions of a second opinion physician may differ from those of the claimant's AP. If of equal weight, the differing opinions would constitute a conflict requiring referral to a referee physician. This is a time-consuming process, however, which is not always necessary. Often a decision can be reached by weighing the medical evidence of record without referral to a referee specialist.

While every case must be reviewed individually, the following are examples of situations in which differences of opinion may be resolved without a referee examination:

(1) The AP (a general practitioner) and the second opinion physician (a Board-certified specialist in the appropriate specialty) differ with respect to an issue such as diagnosis or causal relationship. With all other factors in their medical reports being equal, the opinion of the physician who has training, knowledge, and Board-certification in a specialized medical field related to the claimant's specific injury would usually have greater probative value concerning medical questions pertaining to that field than the opinions of other physicians. In determining the weight of medical opinion, the CE should ensure that all factors in both medical reports are in fact equal prior to assigning the weight to a physician based on medical specialization alone.

(2) The opinions of the AP and the second opinion physician, both Board-certified specialists, differ on an issue such as causal relationship or the nature and extent of work limitations. However, the opinion of one physician is speculative, equivocal, and/or not rationalized, while the opinion of the

other physician is supported by objective findings and is fully rationalized. Medical conclusions unsupported by rationale are of diminished probative value.

j. If the second opinion specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues, the CE should seek clarification or further rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from its physician upon receiving a report that did not adequately address the issues that the OWCP sought to develop. As such, the CE should seek clarification from the referral physician and request a supplemental report to clarify specifically-noted discrepancies or inadequacies in the initial second opinion report.

Only if the second opinion physician does not respond, or does not provide a sufficient response after being asked, should the CE request scheduling with another physician.

2-0810-10 Obtaining Second Opinions for Surgery

10. Obtaining Second Opinions for Surgery. In some instances, the CE may find it necessary to obtain a second opinion prior to authorizing surgery.

a. Emergency surgery may be defined as any procedure which needs to be performed promptly after the onset of a condition or injury in order to preserve life or function of an organ or body part. For emergency surgery, no prior authorization by the Office is required

b. Elective (or non-emergency) surgery may be defined as any procedure which is necessary for the adequate or normal function of an organ or body part, but which does not need to be performed promptly after the onset of the condition in order to achieve its purpose. Prior authorization is required for all elective surgery.

When requesting authorization, the following minimum documentation should be submitted: the name of the surgical procedure; diagnosis of the specific condition(s) which will be treated by the surgery; and the reason surgery is needed for the work-related condition. Any ambiguity or omission in a request for surgery should be resolved by the CE, usually via a written request unless the omission is a simple matter than can be clarified via telephone. If the CE does contact the physician by telephone, a summary of the conversation should be captured on a CA-110 and placed into the case file.

c. When authorization is requested for certain types of elective surgery, the CE must obtain an opinion from the DMA or a second opinion specialist concerning the need for the procedure. The elective surgical procedures involved are: spinal surgery, joint replacements, organ transplants, destructive procedures (e.g., chordotomy, rhizotomy, or amputation of a body part) and experimental surgical procedures.

d. In cases involving spinal surgery, the CE should obtain the minimum documentation described in paragraph 10(b) above and send the case file to the DMA. The DMA will evaluate the request for surgery on the basis of the written record and should provide a rationalized opinion concerning the need for the surgical procedure.

(1) The following guidelines should be used during this evaluation:

(a) The surgical procedure must be related to the claimant's accepted work-related condition.

(b) The history, physical examination, and/or results of pertinent diagnostic tests should support a specific diagnosis.

(c) The medical reports must adequately describe the clinical history and severity of the condition, the results of the physical examination of the claimant, and the results of pertinent diagnostic tests. The presence or absence of complications should also be

described.

(d) As appropriate, an adequate trial of conservative treatment should have been attempted prior to the decision to perform surgery.

(e) The diagnosed condition should warrant surgical intervention according to current medical concepts, and the proposed surgical procedure is within the realm of accepted medical practice.

(2) If the DMA agrees that surgery is warranted, it can be authorized.

(3) If the DMA's opinion is equivocal or negative, or if it indicates the need for clinical data not present in the file, the CE may choose to prepare the file for a second opinion examination. The CE may alternatively choose to ask the AP to submit a report which includes the required clinical data so that the DMA may formulate an opinion on the medical necessity for surgery. Upon receipt of the AP's report, the CE should resubmit the case record to the DMA for comment.

(4) If a second opinion examination is arranged, the usual procedures for notifying the claimant of the second opinion examination should be followed. The Office may also provide the claimant and the AP with a copy of the DMA's opinion which prompted the need for the second opinion examination.

The second opinion physician should provide a report which contains a clinical history, results of a physical examination, results of any diagnostic tests performed, and a reasoned opinion regarding the appropriateness of the proposed surgery and its relationship to the accepted work condition. The physician should use the SOAF provided by the CE as the framework for his or her responses.

(5) If the second opinion physician agrees that surgery is warranted, it can be authorized.

(6) If the second opinion physician does not concur that surgery is warranted, and the CE finds that the opinions of the second opinion specialist and AP are of equal weight after carefully weighing the medical evidence, the case should be referred to a referee medical specialist to resolve the conflict of medical opinion with respect to the surgery request.

If however, the CE finds that the second opinion physician's report holds the weight of medical evidence and supports that surgery is not warranted, the CE should issue a formal decision denying authorization for the surgery, explaining the basis for denial and providing a copy of the specialist's report. The CE should use prudence in assigning the weight of medical opinion to the second opinion specialist in this circumstance.

(7) Even if payment for surgery is denied, compensation for disability resulting from the surgery is payable in cases where the claimant was disabled for work (due to the work injury) prior to the surgery. Such payment may be made regardless of any indications that the period of disability would have been shorter without surgery. In addition, continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

e. In cases involving organ transplants or destructive procedures, the CE should obtain the minimum documentation described in paragraph 10(b) above and send the case file to the DMA. The DMA will evaluate the request for surgery on the basis of the written record and should provide a rationalized opinion concerning the need for the surgical procedure. In many instances, though, the Office will ultimately need to arrange for a second opinion examination to evaluate the request for surgery.

The same sequence of events outlined for spinal surgery applies for these surgical procedures as well. In some instances, though, evaluation of the case record alone may be preferable, and this is acceptable.

f. Where the claimant fails to request prior authorization for surgery, the CE should instruct the claimant to submit the minimum documentation (described in paragraph 10(b) above) from the AP, as well as a copy of the operative report. The CE should then refer the case for an evaluation of the written record by the DMA. Should the DMA conclude that surgery was unnecessary, a referee examination of the case record only will be arranged. A second opinion examination should not be requested under these circumstances, since a physical evaluation after the surgery was performed would have limited value.

Based on the results of this evaluation, the cost of surgery will be reimbursed or a formal decision will be issued denying payment for the surgery. Any such decision should address only the surgical bills, including hospitalization expenses, anesthesiologist's fees, etc. In cases where the claimant was disabled for work prior to the surgery, payment of compensation for disability will not be affected by the decision to deny payment for surgery, and continuing medical care after discharge from the hospital should be authorized just as it would have been if surgery had not been at issue.

g. If the claim has not been adjudicated when authorization for surgery is requested, the CE should advise the claimant and the AP that the OWCP cannot consider a request for surgery before the case is adjudicated; however, the request will be evaluated if the case is accepted. The procedure described in the preceding paragraph will be applied in making such determinations.

h. Where the claimant requests exemption from the requirement that he or she undergo a second opinion examination because of severe pain or inability to travel great distances, the CE should request a report from the AP which substantiates why the claimant’s medical condition precludes the claimant from traveling to or

attending the second opinion examination. If the physician's rationale is deemed reasonable, the CE may permit the claimant to forego the second opinion examination. If the AP's opinion is unclear or unsubstantiated, the CE may send the report to the DMA and ask for an opinion on the reasonableness of the exemption request. If an exemption is granted, the CE will so advise the claimant and AP in writing.

If the exemption request is denied, the CE shall inform the claimant and AP in writing. The CE will also instruct the claimant to attend the scheduled medical appointment and advise the claimant that benefits may be suspended for failure to attend the examination. If the claimant does not report for the scheduled appointment, the claimant's entitlement to benefits may be suspended under 5 U.S.C. 8123(d). See paragraph 13 of this chapter.

2-0810-11 Referee Specialist Examinations

11. Referee Specialist Examinations.

a. The authority for referee medical examinations is found at 5 U.S.C. 8123(a), which states in pertinent part, "if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination." Because this method of resolving conflicts is provided in the FECA, the probative value of the referee specialist's report is great and will normally constitute the weight of the medical evidence of record. In Albert J. Scione, 36 ECAB 717 (1985), the ECAB held that a conflict in medical opinion under 5 U.S.C. 8123(a) cannot occur between two attending physicians, nor can a conflict of medical opinion occur between two DMA's or two second opinion specialists.

b. Prior to referring the case for a referee examination, a conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record, giving consideration to all factors of physician specialty and qualifications, completeness and comprehensiveness of evaluations, and rationale and consistency of opinions.

It may be, as in the case of Jordan M. Carter, 32 ECAB 856 (1981), that no conflict in medical opinion truly exists and, if so, merely declaring a conflict and referring the claimant and the case record out for a supposed impartial examination will not afford that physician's opinion any special weight. However, if a significantly greater weight cannot be assigned by the CE to one opinion, then it is proper to determine that a conflict in medical opinion exists and that a referee medical examination is appropriate.

An agency sponsored fitness for duty examination cannot be considered a second opinion for purposes of creating a conflict in medical evidence.

c. Once a decision has been made to refer a case for a referee examination, a physician should be selected as discussed in FECA PM 3-0500. The referee physician should be provided with a SOAF and a list of pertinent questions or issues to be addressed, which should include a statement outlining the conflict(s) for resolution in the case. The referee physician should also receive a copy of the entire case record.

Surveillance video evidence may also be sent to a referee physician. In such cases, the Office should notify the claimant that it is doing so. See J.M., 58 ECAB 478 (2007). If the claimant requests a copy of the surveillance video, one should be made available, and the claimant given a reasonable opportunity to offer any comment or explanation regarding the accuracy of the recording.

d. Upon review of the referee physician's report, the CE should consider the following:

(1) A conflict of medical opinion relates to an issue and not to a case. A case is referred to a referee based on a conflict of opinion regarding certain

issue(s). While the referee's report may constitute weight on the specified issue(s) based on the authority in 5 U.S.C. 8123(a), opinions expressed with regard to other issues do not necessarily hold weight by mere virtue of the physician being designated as a referee. A CE may still make a finding that the referee holds weight on other issues, beyond the conflict, but that finding may not be made based on the designation as a referee.

(2) The referee specialist's report must actually fulfill the purpose for which it was intended; it must resolve the conflict in medical opinion. The ECAB has stated, "an impartial specialist's report is entitled to greater weight than other evidence of record as long as his conclusion is not vague, speculative or equivocal and is supported by substantial medical reasoning." See James P. Roberts, 31 ECAB 1010 (1980).

Therefore, the CE should ensure that the referee specialist's report is comprehensive, clear and definite, and that it is based on current information and supported by substantial medical reasoning, as well as a review of the case file. See Billie M. Gentry, 38 ECAB 498 (1987). If the report is vague, speculative, incomplete or not rationalized, it is the responsibility of the CE to secure a supplemental report from the referee specialist to correct the defect.

e. If the referee specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues or conflict, the CE should seek clarification or further rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from that physician upon receiving a report that did not adequately address the issues that the Office sought to develop. As such, the CE should seek clarification from the referee physician and request a supplemental report to clarify specifically noted discrepancies or inadequacies in the initial report.

Only if the referee physician does not respond, or does not provide a sufficient response after being asked, should the CE request a new referee examination.

f. Cases returned from a referee medical examiner should not routinely be sent to the DMA for review unless a schedule award is at issue. Where a referee examination was arranged to resolve a conflict created by a DMA with respect to a schedule award issue, that same DMA should not review the referee specialist's report. Instead, another DMA or office medical consultant should review the file. See John W. Slonaker, 35 ECAB 997 (1984).

2-0810-12 Exclusion of Medical Evidence

12. Exclusion of Medical Evidence. In the cases of Carlton L. Owens, 36 ECAB 608 (1985); Aubrey Belnavis, 37 ECAB 206 (1985); and George W. Coast, 36 ECAB 600 (1985), the ECAB established criteria for excluding improperly obtained medical reports from the case record. The purpose of this paragraph is to describe these criteria and the actions which should be taken with respect to reports which must be excluded from the case record.

a. Improper Contact. The Board has required exclusion of medical reports if:

(1) The physician selected for referee examination is regularly involved in performing fitness for duty examinations for the claimant's employing agency. While such physicians may not be used as medical referees, they may be used as second opinion specialists.

(2) A second referee specialist's report is requested before the OWCP has attempted to clarify the original referee specialist's report. Only if the selected physician fails to provide an adequate and clear response after a specific request for clarification may the OWCP seek a second referee specialist's opinion.

(3) A referee medical report is obtained through telephone contact with the physician or submitted as a result of such contact. The CE must refrain from verbal contact to discuss any substantive issue in the case with a physician who has been engaged to provide a referee opinion. All such communication should be in writing.

(4) A medical report is obtained as a result of "leading questions" to the physician in a referee context.

(5) If a surveillance video is provided by the EA directly to a medical specialist acting in the capacity of a referee physician, the CE should advise the EA that the physician’s opinion has been tainted and will be excluded from consideration in the Office’s decision. If there is convincing evidence that the surveillance video is vital to the case and should be used, the CE should direct the EA to provide the OWCP with a copy of the surveillance video to be used in conjunction with a referral to a new referee specialist.

b. Annotating the File. A CE who identifies medical evidence which was obtained improperly should annotate the file so that the referee examination and all accompanying medical reports from the case record are excluded from consideration.

A memorandum for the file must be prepared explaining why the report is excluded from consideration. The referee report, and any clarification reports, should then be deleted and combined with this exclusion memorandum. The exclusion memorandum should be the first page of the combined document. The date of the memorandum will serve as both the author date and received date of this combined document, and it should be indexed in the imaged file as MISC/Memo to File rather than Medical evidence. (Prior to the advent of imaging case documents, the pages

of an excluded medical report were stapled together, with the word “Excluded” and the date written across the front of the report.)

It is not necessary or desirable to remove an excluded report from the case record, nor is it necessary to expunge all mention of an excluded report from factual summaries, formal decisions, and other documents contained in the file. Letters to any physician who is sent the entire case record should instruct the physician to disregard the excluded report, and such reports should be omitted from copies of medical evidence sent to second opinion specialists.

2-0810-13 Suspension of Benefits

13. Suspension of Benefits. This paragraph describes the circumstances under which benefits may be suspended for obstruction of or failure to undergo a medical examination as directed by the OWCP.

a. Legal Provisions. Section 5 U.S.C. 8123(d) states, "if an employee refuses to submit to or obstructs an examination, his right to compensation under this subchapter is suspended until the refusal or obstruction stops. Compensation is not payable while a refusal or obstruction continues, and the period of refusal or obstruction is deducted from the period for which compensation is paid."

In accordance with 20 C.F.R. §10.323, the actions of an employee's representative will be considered the actions of the employee for the purpose of determining whether a claimant refused to submit to, or in any way obstructed, an examination required by the OWCP.

b. To invoke this provision of the law, the CE must ensure that the claimant has been properly notified of his or her responsibilities with respect to the medical examination scheduled.

Once a medical appointment has been scheduled, the claimant and representative, if any, must be notified in writing of the name and address of the physician to whom he or she is being referred, as well as the date and time of the appointment. The notification of the appointment must contain a warning that benefits may be suspended under 5 U.S.C. 8123(d) for failure to report for examination. The claimant must have an opportunity to present any objections to the Office's choice of physician, or for failure to appear for the examination, before the CE acts to suspend compensation.

c. Follow-up Action. If no medical report is received within 30 days of the date of the appointment arranged by the Office, the OWCP should follow up to determine the status of the report. The CE may follow up sooner than 30 days to determine whether the claimant attended the appointment as scheduled. No discussion of the case should take place at the time of this inquiry.

If the claimant reported for examination, the OWCP should inquire when the report may be expected.

d. Failure to Appear and Obstruction. If the claimant does not report for a scheduled appointment or obstructs an examination, he or she should be asked in writing to provide an explanation within 14 days.

Sometimes a functional capacity evaluation is ordered in conjunction with a medical examination. These tests are usually accompanied by a comment from the person administering the test regarding the extent of the patient’s cooperation and the validity of the results. If a tester indicates that the patient exhibited poor effort or did not cooperate with testing ordered in conjunction with a medical examination, a concerted lack of cooperation may be considered obstruction of a medical

examination under 5 U.S.C. 8123(d).

e. If good cause is not established, entitlement to compensation should be suspended in accordance with 5 U.S.C. 8123(d). Benefits should be suspended as of the date of the decision until the date on which claimant agrees to attend the examination. Such agreement to attend the evaluation may be expressed in writing or by telephone (documented on Form CA-110). When the claimant actually reports for examination, payment retroactive to the date on which the claimant agreed to attend the examination may be made.

The claimant's statement that he or she will not appear for an examination is not sufficient to invoke the penalty (Leanna Garlington, 37 ECAB 849 (1986)). Refusal to schedule an examination at the direction of the office is also insufficient to invoke section 8123(d) of the FECA (Herbert L. Dazey, 41 ECAB 271 (1989)).

2-0810-14 Authorizing Medical Treatment and Care

14. Authorizing Medical Treatment and Care. Section 8103 of the FECA states, "The United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation." The ECAB has recognized the OWCP's broad discretion in approving services provided under section 8103, with the only limitation on the OWCP's authority being that of reasonableness. See D.K., 59 ECAB ___ (Docket No. 07-1441, issued October 22, 2007); Lecil E. Stevens, 49 ECAB 673, 675 (1998).

Authorization is requested for a wide variety of medical treatment and equipment; where the need for a particular treatment or type of equipment is well established, expedited approval may be granted.

When needed, though, the CE should develop and evaluate the information from the claimant, AP, service or equipment provider, and (if applicable) the FN or RC assigned to the case. This section describes general authorization procedures. More specific information pertaining to the authorization of diagnostic testing, functional capacity evaluations, special equipment and furniture, health facility memberships, physical therapy, and chiropractic treatment can be found later in this chapter. Part 3 of the PM also discusses medical treatment in detail.

Vehicle and housing modifications are addressed in PM Chapter 2-1800. Transfer or termination of authorization for medical care is discussed in PM Chapter 3-0300.

a. When a request for authorization is received, the CE should review the case for the following information:

(1) A description of the specific test, equipment, service, treatment, and/or facilities needed to address effects of the work-related injury or condition.

(2) Identification of the supplier or provider. The supplier's or provider's contact information is needed. The location of a facility or provider and its proximity to the claimant's home or work may be an important factor.

(3) The anticipated timing, frequency and/or duration for which authorization is requested should be specified.

(4) A statement of medical necessity from the treating physician is needed. The physician's opinion on necessity is to be supported by rationale. The physician's rationale is to include an explanation as to how authorization is expected to be effective in treating the accepted condition. The diagnosis for which the authorization is requested must be identified (if not obvious). The type of request will dictate how much rationale is needed. For instance a request for an MRI for an accepted herniated disc requires little rationale, while a request for health club facility membership for a rotator cuff injury

would require a more detailed explanation.

b. Development of a request for authorization. Upon receipt, the CE should evaluate the information from the physician, claimant, service/equipment provider, and (if appropriate) FN or RC. If the information received is incomplete or if doubt exists as to the appropriateness or need for the authorization requested, the CE may:

(1) Request clarification from the AP.

(2) Request an opinion on necessity from the DMA.

(3) Obtain a second opinion medical examination.

(4) Obtain a referee physician's opinion to resolve any conflict over necessity.

If a second opinion or referee examination is required to establish the need for any authorization, the CE should refer the claimant to a specialist conversant with the issue for determination.

c. If, after any necessary development, the weight of medical evidence does not support authorization for the request, the claimant should be sent written notification and advised of the reasons why authorization is not being given along with any alternatives which can be considered. If requested, the CE should provide a formal decision with appeal rights. Copies of a non-authorization letter by the CE or a formal decision should also be sent to the employing agency and to the AP, as necessary.

A pre-termination notice is not required if the claimant was notified of a specific period of authorization and any specified period of extension. In this circumstance, the OWCP has not led the claimant to expect that the benefit/payment will continue beyond the authorized period. A notice is needed, followed by a formal denial (as appropriate and as described in PM Chapter 2-1400), if an indefinite authorization was provided.

d. If the information received adequately supports the request, it can be authorized.

2-0810-15 Diagnostic Testing

15. Diagnostic Testing. Diagnostic procedures are used to determine the exact nature and extent of the claimant's condition. Such assessments often clarify medical status and may save the claimant additional pain and time loss from work.

a. Development. If a diagnostic procedure such as an MRI, CAT scan, or arthroscopy pertains to the accepted condition, the request should not routinely be developed. Even in the case of arthroscopy, the diagnostic nature of the test should take priority over its surgical nature when authorization is at issue, and the procedure should usually be authorized and paid for without further investigation in a case involving injury to the knee.

b. Sequence of Tests. For many conditions, a standard sequence for such tests exists. For example, an initial x-ray may be followed by a CAT scan or MRI if needed. If the CE is unaware of the usual sequence for a particular condition, or if the nature of the test is unfamiliar, consultation with the FN or DMA may be in order. But unless a specific reason exists to obtain further information, the test should usually be authorized.

2-0810-16 Functional Capacity Evaluations (FCEs)

16. Functional Capacity Evaluations (FCEs). These evaluations may be classified in two types according to their purpose, duration and content: a general-purpose FCE and an FCE for placement into an Occupational Rehabilitation Program (ORP) for work-hardening or work-conditioning.

a. A general-purpose FCE may be authorized by the CE in cases where management of disability calls for clarification of job tolerances, work restrictions, etc., and the AP, second opinion specialist, or referee examiner recommends or requires this service. A request should be submitted for consideration from the requesting physician or facility. Once the request is approved, an authorization letter will be sent to the requestor. If a FN is assigned to the case, the FN should also be notified of the approval.

b. Only a Rehabilitation Specialist can authorize an FCE in connection with an ORP being performed as part of the vocational rehabilitation process (see PM 2-0813).

2-0810-17 Special Equipment and Furniture

17. Special Equipment and Furniture. The OWCP authorizes durable medical equipment to aid in the relief and healing for an accepted work-related condition. These items include those routinely found in medical supply sources, such as braces, crutches, etc. However, sometimes requests are received for equipment or furnishings not commonly obtainable from medical supply sources or prescribed for treatment (e.g., whirlpools, special beds or mattress sets, lift chairs, exercise equipment, motorized scooters, etc.). The OWCP will not approve elaborate or specialized equipment where a more basic alternative is suitable.

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 determine whether rental or purchase is most cost effective, and whether the cost is commensurate with the basic (unadorned) item required for treatment.

a. Development with the physician. The CE should obtain the following evidence from the physician:

(1) A full, specific description of the basic equipment or furnishing required to treat effects of the job-related condition, along with an explanation of how the item will address the effects of the work-related condition and the anticipated improvement.

(2) The anticipated duration of the need for the item (in order to determine whether rental or purchase is appropriate).

b. Development with the claimant. The CE should also obtain the following evidence from the claimant:

(1) The full name of two or three suppliers, along with complete contact information for each.

(2) From each potential provider, a signed statement describing in detail the basic, unadorned item meeting the physician's specifications, and a breakdown of all costs, including delivery, set-up, etc. If the claimant wants a more elaborate item (e.g., a queen-size bed vs. a single needed for claimant), the claimant should submit a price quote for the basic item only. It is the claimant’s responsibility to pay for any enhancements.

c. Review and Authorization. If the information received is incomplete or doubt exists about the suitability, appropriateness, or need for the equipment or furniture, the CE should undertake suitable development, such as requesting clarification from the AP or obtaining a second opinion examination.

If, after sufficient development, the request can be authorized, the claimant should be advised in writing.

d. Denial of Approval. If the evidence does not support the lease or purchase of

the requested item, the CE should advise the claimant in writing, explaining the reason(s) and listing the alternatives which can be considered. A formal decision with appeal rights should be issued, if requested.

2-0810-18 Health Club/Spa Membership

18. Health Club/Spa Membership. Such memberships may be authorized if rationalized medical evidence establishes they would be therapeutic to treat the effects of an injury. In all cases where such memberships are at issue, the CE must determine that the membership is likely to be effective and cost efficient, given that exercises performed at such facilities are generally done without supervision, the membership term may be incompatible with or extend beyond the duration of the prescribed program, and membership dues often include charges for services not related to the treatment regimen. The OWCP will not approve an elaborate facility or service where a more basic one is suitable.

a. Development with the physician. The CE should obtain the following evidence from the physician:

(1) A description of the specific therapy and exercise routine needed to address effects of the work-related injury, including a description of the specific equipment or facilities needed to safely perform the prescribed regimen.

(2) The frequency with which exercises should be performed and the anticipated duration of the recommended regimen.

(3) The nature and extent of supervision, if any, that the physician feels is required for safety while the claimant is performing the exercises.

(4) The physician's opinion of the anticipated or actual effects of the regimen, the treatment goals sought or attained, and the frequency of the AP's examinations to determine the effectiveness or ongoing need for the program.

(5) A statement directly addressing whether the exercise routine can be performed at home, and the viability of a public facility, such as a community recreation center or pool, in accomplishing the treatment goals.

b. Development with the claimant. The CE should also obtain the following evidence from the claimant:

(1) The full name and address, and distance from the claimant's home or work, of suitable public facilities.

(2) The full name and address, and distance from the claimant's home or work, of suitable commercial facilities.

(3) If applicable, the claimant's specific reason(s) for requesting approval of a commercial facility if a suitable public facility is available or the AP has indicated the regimen can be performed at home.

(4) A signed statement from the health club or spa manager verifying that

the facility is fully suitable for the exercise routine prescribed by the physician. The manager should also provide detailed fees and charges for various membership options and terms (e.g., short-term vs. lifetime membership). The statement should describe all facilities, services, and special charges not included in the membership fee.

The CA-6043 letter can be used for this development of these issues.

c. Review and Authorization. If the information received is incomplete or doubt exists about the suitability, appropriateness, or need for the membership, the CE should undertake suitable development, such as requesting clarification from the AP, consulting with the DMA or obtaining a second opinion examination.

If the information received adequately supports the request, the CE may approve membership, provided the cost does not exceed $750. Requests for higher amounts should be referred to the Senior CE or Supervisory CE with a written recommendation explaining the basis for approval.

Only individual (not family or group) health club memberships may be approved, and usually only for period of six months at a time. The claimant should be advised of the period of approval. The claimant should also be advised that if a further period of approval is requested, a request with a medical report explaining the gains achieved to date and supporting an extension for a specified period, should be submitted approximately 45 days prior to the expiration of the current membership term for consideration.

d. Denial of Approval. If the evidence does not support paying for a membership, the CE should advise the claimant in writing, explaining the reason(s) and listing the alternatives which can be considered. A formal decision with appeal rights should be issued, if requested.

2-0810-19 Physical Therapy

19. Physical Therapy. For most orthopedic injuries, physical therapy (PT) services within the first 120 days after a traumatic injury are allowed without any prior authorization required. It is also customary to automatically authorize PT post operatively for orthopedic surgeries, usually for a period of 60 days post surgery. If a request for therapy beyond these time frames is received, the CE needs to review the file to determine whether further services should be authorized.

a. PT requests must include the following: specific CPT-4 codes, number of units, frequency and duration of treatment. This request must also be accompanied by a prescription and treatment plan from the attending physician.

b. Evaluating PT requests. To evaluate the need for therapy beyond the initial period of authorization, the CE is to review the case for the following medical evidence:

(1) An established need for PT directed to the accepted condition or to an accepted complication of the claimant's injury or condition, including surgery.

(2) The specific modalities being prescribed, which should include some form of active PT.

(3) The existence of a functional deficit where the additional therapy is expected to produce some functional improvement. Pain alone does not constitute a functional deficit. To authorize additional physical therapy for pain or to maintain function, the CE should ensure that the pain is associated with measurable objective findings such as muscle spasm, atrophy and/or radiologic changes in joints, muscles or bones, or that pain has placed measurable limitations upon the claimant's physical activities.

c. Prior to authorizing additional PT, medical development may be needed if the file does not substantiate the need for ongoing therapy. The CE may need to request further information from the physician, such as the following:

(1) Specific modalities, procedures and/or tests and measures to be administered.

(2) Specific functional deficits which are to be treated, including a description of how these deficits affect the claimant's physical activities.

(3) Specific functional goals of the additional therapy.

(4) Appropriateness of a patient-directed home exercise program as an alternative to supervised physical therapy, especially in light of the efficacy of past supervised therapy and the magnitude of any expected functional improvement.

d. Additional PT may be approved if the need has been established as outlined

above.

e. Denial of Approval. If there is insufficient evidence, after development, no further physical therapy should be authorized. If the claimant inquires, the CE should explain the reason(s) in writing. A formal decision with appeal rights should be issued, if requested.

f. Extended PT may be approved for severe brain or spinal cord injuries, extensive second or third degree burns, or other severe injuries that have rendered the claimant bed-ridden permanently or for an extended period of time. The CE may authorize physical therapy services for up to one year in these circumstances. However, the accepted condition(s) must support this exception.

2-0810-20 Authorizations for Chiropractic and Osteopathic Treatment

20. Authorizations for Chiropractic and Osteopathic Treatment. If a spinal subluxation has been accepted, manual manipulation of the spine by a chiropractor is payable. However, other physical therapy services, even if performed by a chiropractor, are subject to the requirements in the preceding paragraph. When the AP prescribes manipulative treatment by a chiropractor or an osteopathic physician, this therapy is subject to the above procedures. Physical therapy services provided by a chiropractor or osteopath must be recommended and directed by the AP.

2-0810-21 Attendant Allowance

21. Attendant Allowance. 20 CFR §10.314 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense directly to the provider of services under 5 U.S.C. 8103.

Prior to the January 1999 revision to the Federal Regulations, an attendant allowance was paid directly to the claimant. Any such allowance approved prior to January 1999 will continue to be paid to the claimant until the need for the attendant ceases. Any new claims for an attendant allowance will be processed under §10.314, consistent with the guidance in this chapter.

a. Development of a new request. Where the evidence strongly suggests that the claimant may require the services of an attendant, or where the claimant inquires about such entitlement, the CE should request further information from both the claimant and the physician.

b. Evaluating the request. When making a determination on the claimant's entitlement to an attendant, the CE is to consider the following factors:

(1) The particular kinds of activities for which assistance is needed. The assistance must be for personal needs such as bathing or dressing, not for such tasks as cooking or housekeeping.

(2) The need for daily assistance in these activities.

(3) The nature of the disability.

c. Authorization. When the services of an attendant are approved, the CE should prepare a memorandum for the file outlining the reasons for approving the attendant allowance, and stating the period for which it is approved. A CE may approve the services of an attendant for up to one year if the medical evidence supports a long-term need.

If the services of an attendant are required beyond that period, the CE should prepare a memorandum to the Supervisory Claims Examiner (SCE) making recommendations and requesting approval for a longer period. If the SCE concurs with a longer authorization period, or that an attendant will be needed indefinitely, the SCE may approve a longer period. This decision should be documented in the case file.

d. The provider should submit an itemized bill for services directly to the OWCP as directed in 20 CFR §10.801.

e. Continued entitlement to the attendant allowance should be verified by the CE annually during the periodic entitlement review process. General procedures for determining continued entitlement are contained in FECA PM 2-0812.

2-0810-22 Claimants in Prison

22. Claimants in Prison. Incarcerated persons do not lose entitlement to medical treatment for work-related injuries simply because they are imprisoned.

Medical treatment and examinations should be arranged through prison officials. It may be sufficient to obtain routine medical services from the prison physician. If needed, and with the cooperation of prison authorities, the claimant may be taken to a specialist's office or arrangements may be made for the specialist to visit the prison to see the claimant. Such arrangements may be made not only for treatment and periodic examinations, but also to obtain physical work limitations for use in determining the claimant's wage-earning capacity. Copies of correspondence with prison officials regarding medical examination and treatment should be sent to the claimant (and his or her representative).

2-0811 Nurse Case Management

Chapter 2-811, Nurse Case Management

1. Purpose and Scope. This chapter discusses the early intervention phase of disability management claims. The focus is primarily on the necessity and appropriateness of nursing intervention and techniques for the management of disability claims at the earliest possible point to facilitate return to work. It outlines the different roles and types of nurses, provides guidance to the Claims Examiner (CE) regarding how and when nursing intervention should be undertaken, and discusses the necessary components of successful claims management during this phase.

See FECA Procedure Manual (PM) chapter 2-0600 for a complete overview of the Disability Management process.

See also FECA 3-0201 and 3-0202 for more detailed information on the management of contract nurses.

2. Introduction. The Office of Workers' Compensation Programs (OWCP) is committed to seeing that benefits for compensation and medical services are appropriate and provided timely. OWCP is also committed to assisting injured workers in returning to work as soon as possible in order to minimize the period of disability. Benefits should not continue after the effects of the work-related condition have ceased.

Management of disability claims begins as soon as a new claim is received indicating that the claimant has lost time from work as a result of the injury or is disabled from his or her date of injury position. The CE assists the claimant in returning to work as soon as possible; however, the return-to-work effort consists of more than just CE intervention. The best outcomes stem from an active team approach where OWCP, the employing agency (EA), the claimant, and the medical providers use all available tools to facilitate medical recovery and a sustainable return to work.

Nurse intervention is an integral part of the overall disability management of a claim, with a registered nurse providing liaison services to assist in medical and claims management with a return-to-work focus. However, even when a nurse has been assigned to a case, the CE remains responsible for the management and overall direction of the case.

The CE uses the Disability Management (DM) Tracking system in iFECS to record actions taken during disability management, including those taken with regard to the assigned nurse. Additionally, the interaction between the DM Tracking system and the Nurse/Rehabilitation Tracking System (NRTS) provides the ability to effectively track and manage a disability claim from assignment to closure. PM Chapter 2-0601 discusses the DM Tracking system in detail.

3. Types of Nurses. The OWCP has contracted with registered nurses who have case management experience to provide intervention at the earliest stages of disability management.

A Staff Nurse assigned to each district office is responsible for oversight of the contracted nurses.

a. Staff Nurse. As part of the oversight process, the Staff Nurse (SN) should see there is a sufficient number contract nurses to service the district office's needs. The SN assigns contact nurses to specific cases; monitors contract nurses' performance in correlation to both the contract specifications and the quality of services provided; reviews nurse reports for completeness and timeliness prior to authorizing payment of bills; and communicates with the CE as needed with regard to issues that arise during the nurse intervention phase.

b. Continuation of Pay (COP) Nurses. COP Nurses (CN) are registered nurses assigned in traumatic injury cases where the injured worker has immediate time loss and has not returned to work within seven (7) days following the date of work stoppage. The CN is strictly a triage nurse and all work is performed telephonically. The CN contacts the employee, the EA and the treating physician. Within seven (7) days of the case assignment, the CN initiates contact with all three to obtain the necessary information and then closes the case. The CN closure report should contain the return-to-work status and provide a recommendation regarding early intervention and assignment to a field nurse.

c. Field Nurses. The Field Nurse (FN) is a registered nurse who assists in the management of disability claims in a number of ways. The FN assists in coordinating medical care during the recovery period and helps to facilitate a safe and timely return to work. The FN also acts as liaison between the CE, claimant, EA, and medical providers. The FN's contact is generally in person; however, in some instances the activity may be only telephonic in nature.

4. The COP Nurse (CN). Although nurse intervention is not extensive during the COP period, the medical knowledge and experience of a CN enables the CE to identify cases that require more extensive intervention due to the severity of the injury, contemplated surgical intervention, or lost time from work.

a. CN Assignment. Based on the data entered when a traumatic injury case is created (specifically, the date work was stopped), a case becomes automatically eligible for a CN assignment if the claimant does not return to work within 7 days of the date the claimant stopped work. This assignment occurs even if the case has not yet been formally accepted. If the EA reports a return to work prior to CN assignment, a CN should not be assigned. CN assignments are done electronically through iFECS, and necessary information is accessed by the CN via remote access to iFECS.

Note – As COP is not payable in occupational disease cases, CN assignments are not made in those cases.

b. CN Actions. Upon receipt of the assignment, the CN should make a three-point contact in order to effectively triage the case, and then report these

findings via a COP Nurse Report to the SN and CE.

(1) Claimant – The CN should make initial contact with the claimant and obtain details concerning the injury. The CN should also determine whether the claimant has a treating physician, and, if so, contact information should be obtained.

(2) Employing Agency (EA) – The CN should contact the EA to confirm the claimant's work status and determine whether appropriate work accommodations are going to be available during recovery. The CN can also discuss with the EA the possibility of a future FN assignment in a particular case.

(3) Attending Physician – The CN should contact the physician's office to obtain information concerning treatment and the date of the claimant's next appointment. The CN can also advise whether work accommodations can be made at the agency, if known, and provide general information about the FECA program.

Once information has been obtained from the claimant, EA and attending physician, the CN provides that information, via a written report, to the SN and CE. Any other relevant information pertaining to possible issues for a foreseeable recovery or return-to-work barriers should also be included. The CN should also make a specific recommendation pertaining to whether a FN assignment would be beneficial.

c. CN Timeframes. The CN should obtain the necessary information, as outlined above, and submit a closure report within 7 days of assignment. There is a limited amount of flexibility with this 7-day timeframe. If the CN has determined that the claimant will be returning to work within the following week, and the specific contact information supporting a definitive return-to-work date has been obtained, the CN case can be held open beyond the 7-day window to verify and report the return to work. CN closure, even with this kind of limited extension, should occur no later than 14 days after assignment.

d. Once the CN Closure Report is received, the SN reviews it and submits the bill for payment. At that point, the COP Nurse Report will be viewable by the CE, who can use the information provided to determine the next appropriate step for the case. The closure type and date will also be visible to the EA in the Agency Query System (AQS) at that time.

If the CN closes the case and the claimant has not returned to work in a full-time capacity, the CE should review the case for adjudication. The CE can also use the information obtained by the CN to expedite adjudication or guide the next intervention action. The CE should also review the case for appropriateness of assignment to an FN, as a case may be assigned to an FN even if the COP period has not yet expired. A FN may also be assigned if the claimant has returned to work full time, but in only a limited duty capacity.

5. The Field Nurse (FN). A FN is assigned when work-related disability has been identified. Unlike CN assignments, the CE must initiate a referral to a FN. A FN's contact is generally in person; however, in some instances the activity may be only telephonic in nature (e.g. in an instance where there is no contract nurse in the vicinity of the claimant's locale). Whether the nurse's contacts during these kinds of assignments are in the field or only telephonic in nature, they are all called FNs. The FN's responsibilities include, but are not limited to, the following:

a. Developing a rapport with the claimant and answering questions about what to expect from OWCP, while at the same time clearly establishing the return-to-work goal for the claimant from the outset.

b. Making determinations about the initial extent of the injury, treatment necessary for recovery, and return-to-work expectations (using the CN's report, if available, as part of this process).

c. Attending the claimant's medical appointments to facilitate communication about return to work and ease any authorization difficulties the claimant may be encountering.

d. Obtaining functional capacities, restrictions and limitations from the physician as early as possible, and then providing these to the EA and exploring job modification options.

e. Identifying possible barriers to the claimant's return to work and then developing a plan of action with the CE to resolve the identified barriers.

f. Continual evaluation of the likelihood of return to work with the EA and physician, with the goal of following the plan through to successful full duty return to work and closure.

g. Communicating regularly with the medical providers, claimant, EA, SN and CE to keep all parties informed of the status of the case to facilitate a timely, sustainable return to work.

h. Making recommendations for vocational rehabilitation when necessary.

6. When a Field Nurse is Needed. The need for a FN can occur in many different situations. Some of the most common situations in which referral for FN services is needed are: coordinating medical care, obtaining work limitations, assisting the CE in resolving medical issues, visiting the work site and ensuring that duties of the position do not exceed the medical limitations as represented by the weight of medical evidence established by OWCP, and addressing any problems the employee may have in adjusting to the work setting.

a. Nurse services are a valuable tool for assisting claimants in returning to work and assisting CEs in moving a case towards resolution. Early referral for nurse intervention services is critical to successful disability management.

b. Nurse intervention should begin as soon as possible after the injury occurs in accepted cases if the claimant has not returned to work, even if the Continuation of Pay (COP) period has not yet expired. The referral for FN services may also be made if the claimant has returned to work but is disabled from performing his or her date of injury position.

c. The need for a nurse referral, in general, can be established with any situation where the claimant is not working his/her full regular duty. The following is a breakdown of some scenarios that illustrate when a case may be considered for referral for nurse intervention services:

(1) The claimant is temporarily totally disabled (TTD);

(2) The claimant is working full time but with restrictions, and a return to less restrictive work, a full-duty release, or establishing permanent restrictions is being pursued;

(3) The claimant is working less than full time with or without restrictions, and an increase in work hours, a return to less restrictive work, a full-duty release, or establishing permanent restrictions is being pursued;

(4) Work tolerance limitations have been obtained, but outstanding medical issues hinder or preclude a return to work. The FN can assist with the outstanding medical issue (e.g. pain management, medication, treatment plan, specialist consultations, etc.);

(5) Surgery is authorized and monitoring medical recovery and coordinating post operative care is needed;

(6) The return to work date stated does not coincide with the severity of the original injury;

(7) The return to work date is extended without clear and valid medical reasons;

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

(9) The claimant has sustained a catastrophic injury and coordination of medical care is needed; or

(10) The claimant stops work (sustains a recurrence) after an initial return to work effort.

d. Referral for nurse intervention services can also be taken for specific task-related actions later in the life of a case, even after a prior nurse closure has occurred. These are generally shorter assignments based on a specific task. Some

examples of these instances are:

(1) The claimant's work tolerance limitations are in question, and the CE determines that with the assistance of a FN, clarification of the claimant's work capabilities can be obtained;

(2) When questions arise regarding the claimant's current medical status, the FN can meet with the attending physician to obtain a medical opinion on a pending medical issue, assist with obtaining medical records, etc.; or

(3) A FN would be beneficial to assist the CE and/or claimant with the coordination of medical care due to the severity or complexity of the claimant's medical condition.

7. Field Nurse Referral. Once a CE has decided to refer a case for nurse intervention, the CE should complete a nurse referral.

a. The nurse referral should provide specific information for the SN to utilize in making the referral to the FN, such as: the claimant's name, address, phone number; the EA name, address, contact person, if known (most likely the EA Injury Compensation Specialist), and phone number; whether there is a an attorney or representative authorized in the case; the accepted conditions and ICD-9 codes; the claimant's date of injury and date of birth; the claimant's current work status; the responsible CE's name; and the recognized attending physician's contact information, including name and phone number.

b. The completed nurse referral should also note the goals of the intervention and the issues which the FN should address with the physician (e.g., obtaining a description of work limitations or treatment plan) and any pending adjudicatory actions (e.g., an imminent second opinion referral). The referral should be specific to the circumstances of the case.

c. Along with the referral, the FN should be provided a copy of the pertinent medical records from the file, which may also include a copy of a current Statement of Accepted Facts (SOAF), if available.

8. Field Nurse Assignment. If the claimant has not returned to regular full duty and the case has been accepted, a FN can be assigned.

a. FN assignments should usually be made with the expectation of in-person contact by the FN, since the FN may more easily assess the claimant's environment and job situation in a personal visit. An assignment may be limited to telephonic intervention, though, in uncomplicated cases, or in instances where there is no contract nurse available in the claimant's locale. If the assignment is to be only telephonic in nature, the SN should clearly indicate this in the referral documentation, but there are no differences with regard to the timeframes.

b. Within one week of receipt of the file the FN should:

(1) Contact the injured worker for initial assessment;

(2) Contact the attending physician for a treatment plan, projected return-to-work date, and completion of an OWCP-5 (or equivalent). In addition, the attending physician should be notified that light duty may be available when the injured worker is able to return to some form of work;

(3) Contact the EA regarding availability of light duty and return-to-work options; and

(4) Contact the CE and provide a synopsis of medical issues, current work status, and estimated dates for return-to-work at light or regular duty.

If the FN is unable to meet this one-week timeframe (e.g. the treating physician cannot be available for 2 weeks), notification should be made to the SN and CE.

c. After the initial status report from the FN, if necessary, the CE should direct the FN with regard to what course of action to pursue. This type of direction should continue throughout nurse intervention depending on the information provided by the FN.

d. Within one month of assignment, the FN should obtain a position description for the date of injury (DOI) job, which includes the actual physical requirements. If the claimant has been working a light duty job since the injury occurred, the FN should also obtain this documentation for the light duty job. The FN should also have a face-to-face meeting and job-site walk through (when possible) with the EA to assess potential job modification possibilities.

e. The FN should submit medical evidence as soon as it is received and contact the CE to report the following:

(1) Changes in the claimant's medical condition (e.g., newly diagnosed conditions whether work-related or not, requests for surgery, etc.).

(2) Claim expansion (e.g. the attending physician may request an expansion of the work-related conditions in the case to include a diagnosis that better matches the claimant's work-related condition).

(3) If the EA states it will not make light duty work available, or if the EA withdraws light duty work.

(4) Report of a new injury, whether sustained at work or not.

(5) Return-to-work status or changes in work status (e.g. full-time to part-time or change in hours worked). This requires immediate

notification.

(6) Release to return to work (with follow-up verification of actual the return-to-work date).

(7) Any event that significantly impacts a claimant's ability to return to work or seek treatment (e.g. the death of a family member, personnel issues, etc.).

(8) The need for a second opinion examination.

(9) Claimant's willingness or unwillingness to cooperate with the treatment recommendations of his/her physician and the return-to-work effort.

f. The FN should submit a monthly written progress report that includes:

(1) Current Work Status. This includes the number of hours (if working), the effective return-to-work date, and type of work, with EA confirmation; or the projected return-to-work date (if not working).

(2) Claimant Contact. This includes a synopsis of the information obtained and an assessment of the home environment and family structure, as well as the date/type of the contacts. Information pertaining to the home environment will usually only be documented in the initial assessment report and need only be referenced in subsequent reports if the FN determines that such issues present an ongoing barrier to rehab/recovery. Also, depending on the nature of the case, assessment of the home environment may not be necessary.

(3) Physician Contact. This includes the date of medical visits; physician requests (surgical approval, physical therapy, etc.), and detailed requests made by the FN to the physician based on the treatment plan.

(4) EA Contact. This includes the job site evaluation performed and date, as well as the name of contact person with whom job accommodations were discussed.

(5) Planned Actions and Comments. This includes specific actions the FN plans to take during the next reporting period, e.g. the next physician appointment, possible increase in work hours, job site walk through, etc.

(6) Barriers or Issues. This includes any barriers to medical recovery or the return-to-work effort. This may also include issues that the FN

requires CE direction on before moving forward. While these issues should be communicated prior to the monthly report if significant, the

CE should always review this section of the report carefully to determine whether intervention is needed.

g. The FN should submit a closure report when directed by the CE or SN to close the case. When a case is scheduled for closure of nursing services, the FN should inform the injured worker, physician, and EA of the closure.

h. Non-cooperation. Sometimes a claimant may not wish to cooperate with the nurse intervention program. If this occurs, the CE should obtain specific details regarding the situation. While OWCP cannot issue any type of sanction specifically for non-cooperation with the FN, the CE should take appropriate follow-up action to address the situation if it is hindering recovery and return-to-work. Several options are available, but each case must be assessed individually.

(1) If work tolerance limitations are already on file, the CE can refer the case for vocational rehabilitation services.

(2) The CE may wish to hold a conference with the claimant and FN to explain the purpose of the nurse intervention program and the advantages for the claimant.

(3) If the FN can still be productive without direct contact with the claimant, the FN may remain assigned to the case and complete further tasks as directed by the CE.

(4) In other instances, it may be best to close the case for nurse intervention while the CE medically manages the case and possibly refers the case for vocational rehabilitation services at a later date.

9. Communication. Returning injured employees to work and minimizing the effects of a work injury are goals that require regular and timely communication between the CE, SN, and FN. Effective, well directed, and organized disability management can be achieved with this team approach.

a. Communication between the CE and the SN.

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

(2) The SN should communicate with the CE on cases assigned to FNs regarding important or time sensitive information so that action can be taken by the CE, if necessary.

b. Communication between the CE and the FN. During the period of FN

intervention, the CE and the FN will confer, either by telephone or written communication, to determine the next action. Timely response to FN inquiries is crucial to successful case management. The CE determines the best approach to achieve progress in the case and directs the FN in obtaining necessary information or completing specific tasks needed to achieve those goals.

The FN will report to OWCP, either by telephone, in writing, or both. Written reports are usually required every 30 days, but effective disability management hinges on more frequent communication in most cases. More immediate communication can be accomplished via the phone or email.

Note – Email may be used by the CE or SN to direct the activities of the FN during the nurse intervention period. If email is used, all protocols to safeguard Personally Identifiable Information (PII) must be followed (e.g. no identifying information in the subject line, and no reference to the claimant's complete SSN, name, or other protected PII in any part of the email message). Case specific communication concerning significant case actions should be placed in the case file.

(1) When the CE refers a case for nurse intervention, the CE should communicate via the nurse referral: the goals of the intervention, any issues that the FN should address with the physician, and any pending adjudicatory actions.

(2) The FN will report to the CE by telephone, in writing, or both. The FN may note such information as the attending physician's opinion concerning length of disability, work limitations, etc. The CE may use this information as the basis for questions to the physician but should not base adjudicatory actions on it, as a FN report is not medical evidence. However, if the FN arranges for submission of a medical report from the physician, the physician's report may be used for adjudicatory purposes.

(3) Periodically during the FN intervention period, the FN and the CE will discuss the specific circumstances of the case and confer to determine the

next course of action in order to minimize disability and the effects of the work injury.

(4) The CE should regularly assess the claimant's medical condition and return-to-work status and decide what type of intervention is appropriate. For instance, the FN may recommend a second opinion examination, or recommend medical or vocational rehabilitation services, or other kinds of evaluation. The CE should promptly respond and take whatever claims intervention is needed.

(5) The FN should confirm the closure date with the CE prior to closing the case. When directed to close the case, the FN should contact the claimant, physician and the EA to advise them of the closure and refer them to the CE if they have any concerns. The FN should also notify the SN and then submit a

closure report.

10. Length of Field Nurse Assignment. The length of FN assignment will depend on the circumstances of the case. Factors such as the type of injury, the medical conditions involved, and the availability of light or modified duty may play a role.

a. Initial Assignment. A FN will generally be assigned to a case for 120 days initially, regardless of whether the claimant has returned to work already or not; however, a shorter assignment may be considered. The CE should consult with the SN for additional guidance if needed.

Note – This assignment is made based on a unique period of disability. For instance, if a FN is assigned and the claimant returns to work during that assignment but then sustains a recurrence for a period of work-related disability, a FN can be reassigned and the initial assignment period (and the remainder of the protocol outlined in this section) begins again in a new DM Tracking record. See FECA PM 2-0601 for more information on creating DM tracking records.

b. Return-to-work monitoring. The full 120 days may not be needed when the claimant is already working at the time of FN assignment.

(1) Light Duty monitoring. If the FN obtains medical evidence indicating no full duty release, the claimant has permanent/stable work restrictions and has been working a job within the work tolerance limitations for 60 days while the FN has been assigned, the FN assignment may end. The FN should generally provide light duty follow up and oversight for a period of 60 days after the claimant has returned to work in a light duty position, unless the rationale for a longer period of monitoring is provided.

(2) Full Duty monitoring. If the claimant returns to work full duty, the FN should follow the case for 30 days (not 60), unless there is a specific reason for the longer 60-day monitoring period.

(3) Automatic extensions. An extension is not needed if the return to work occurs early enough in the 120-day period such that the 60 day monitoring will be completed prior to the 120 days. If the full 120 days has not been used, though, and the 60-day monitoring period is complete, the remaining days can be used if needed without further documentation (e.g. if the FN may be able to obtain a full duty release).

An extension to complete the return-to-work monitoring described in this paragraph is considered to be automatic, even if it takes the assignment period past the 120-day initial assignment period. As long as the return-to-work date (and type) is clearly identified in the file, the monitoring (and any necessary extension) is automatic.

c. At the end of 120 days, the CE must evaluate the case and determine whether further FN services are necessary. For optimal case management results,

collaboration between the CE and SN should occur when extensions are to be granted, or if there is any question regarding the appropriateness of FN closure.

(1) If the claimant has not returned to work, and there is no clear indication that FN services would be useful for a specific purpose, the FN should be closed. This closure should be documented in the file, and the CE

should take another appropriate disability management intervention action promptly thereafter in an effort to move the case towards a resolution.

(2) If the claimant has not returned to work, and there is something specific the FN could do within the next 30 to 60 days to further the return-to-work efforts, the CE can extend the FN for 30 or 60 days at his or her discretion, as long as there is a clear indication that FN services would be useful for a specific purpose and that purpose/direction has been provided to the FN as clearly evidenced in the file.

For instance, if on day 105 the attending physician advises that after 3 more weeks of physical therapy, he will be able to provide work tolerance limitations, an extension could be authorized. Another example would be a case where the physician provided work restrictions towards the end of the 120-day period and the FN indicated that she was working with the EA on the formulation of a job offer, an extension could be granted to facilitate formalizing any such offer of employment.

If the CE authorizes a 30-day extension initially and later decides that an additional 30 days is needed, the same kind of rationale (purposeful decision making), direction, and file documentation is needed.

(3) If the claimant had an initial return to work during the first 120 days, and the 60 day monitoring of that return to work takes the FN past 120 days, the extension to follow up past the 120 days is automatic through the completion of that 60-day period. No extra file documentation is needed through day 60 of the light duty return to work (or day 30 for full duty).

(4) If the claimant had been working at the time of the initial assignment and has not been released to full duty and the work status has not changed, the FN should be closed. An extension may be granted if one of the following is expected (as evidenced in the file) within the next 30-60 days: a) full duty release, b) permanent or less restrictive work tolerance limitations, or 3) permanent job offer. Once this particular goal is accomplished, the FN should be closed. In these situations, where the claimant was already working at the time of the nurse assignment, the assignment period should not usually exceed 180 days.

d. At the end of 180 days, supervisory approval of any further extension is needed, with one exception.

(1) The 180-day automatic exception - If the claimant had an initial return to work during an extension period (between day 120 and day 180), and the monitoring of that return to work takes the FN past 180 days, the extension to follow for the 30 or 60 days is automatic through the completion of that 30 or 60-day period. No extra file documentation is needed through day 60 of the light duty return to work (or day 30 for full duty), but the FN assignment should be closed at the end of that monitoring period.

(2) Other than the automatic extension noted above, any assignment past 180 days needs an explanation in the file regarding why the extension is needed and what is expected during the next period. There should be a clear

indication that FN services would be useful for a specific purpose and that purpose/direction has been provided to the FN as clearly evidenced in the file. Extensions after the 180-day mark should usually be granted in 30 or 60-day increments (except for catastrophic cases). If an initial extension (after 180 days) is authorized, then another such extension is authorized, the same kind of rationale (purposeful decision making), direction, and file documentation is needed.

A typical scenario may occur when surgery is performed during the initial 120-day period, and if, despite a delayed recovery, the treating physician presents a clear prospect of a return to work release at the end of the 180-day assignment period, the extension of services could be given so that the FN can provide the EA with those restrictions and work with the EA on an appropriate job offer.

(3) If the claimant has an initial return to work during an extension period (after 180 days), the extension to follow is automatic through the completion of the 30/60 (full duty/light duty) period. No extra file documentation is needed for the return to work extension.

e. After 10 months of FN intervention, regardless of prior extensions, nurse intervention services should cease unless the case is within its first 30/60 day return-to-work monitoring period or is a true catastrophic case requiring ongoing intervention.

If the Supervisor (based on a recommendation from the CE and SN) believes that ongoing FN services would be useful (beyond 10 months) due to the unique circumstances of a given case (e.g. a case where major surgery was significantly delayed, and then the claimant encountered significant obstacles during medical recovery which took longer than expected to resolve), the Supervisor may authorize an additional extension as long as the file is documented appropriately as outlined above.

f. The assignment period for task-based assignments is significantly shorter. These assignments occur later in the life of a case, usually after early nurse intervention services have expired, and the goal is very task oriented. When

assigned, the FN should be notified of the specific task and the time period allotted for completion of the task. Once that specific task has been accomplished, FN services should be closed. Usually these assignments should last no longer than 30 -60 days.

11. Dual Tracking. The CE has the option to take a dual track intervention approach on certain cases. Dual tracking is when both a FN and rehabilitation counselor (RC) are assigned to a case at the same time. The CE should also refer to FECA PM Chapter 2-0600-8, 2-0600-9 and 2-0813-5. Accepted cases with active FN involvement may be assigned to a RC in order to facilitate an earlier return to employment. The FN may recommend such an approach to the CE, or the CE can determine the benefit and direct such action independently.

There are certain instances when this dual intervention is appropriate and there are specific and distinct goals for both the FN and RC.

a. Criteria for Dual Track Intervention. The dual track approach is warranted in two basic circumstances:

(1) Placement Previous Employer. If the EA is trying to accommodate the claimant's work restrictions, but is having difficulty formulating a position, the FN or CE can recommend the services of an OWCP RC. For instance, if vocational testing, an ergonomic evaluation, or assistive technology would enable the EA to offer a job to the claimant or explore job opportunities for placement in another departmental position, dual assignment of an RC in conjunction with the FN may be appropriate and useful.

(2) Placement New Employer. If the claimant has a medical condition which is likely to lead to permanent work restrictions, and there is no possibility that the EA would be able to accommodate those restrictions, the claimant may benefit from a dual approach where the FN continues to assist with medical recovery while the RC begins early vocational assessment and planning.

b. Purpose and Scope of Dual Tracking. The purpose of the dual track approach is to obtain medical recovery as soon as possible while at the same time achieving an early return to work. This may be with either the EA or a different employer.

(1) The FN primarily works with the treating physician to obtain as early a recovery as possible and maximum work tolerance limitations.

(2) The RC can provide rehabilitation services to the claimant and the EA that will allow the EA to formulate a suitable job offer, e.g. vocational testing, a transferable skills analysis, an ergonomic evaluation, etc. Or the RC can work with the claimant to determine his/her skill level and the potential labor market for medically suitable employment if the EA is unable to accommodate the claimant.

(3) If the EA cannot accommodate the claimant's work restrictions, once the FN has obtained stable, well-defined work tolerance limitations, nurse intervention will end and the vocational rehabilitation program will continue.

(4) The FN and RC should communicate with one another during this process. Also, the FN will work with the SN, and the RC will work with the rehabilitation specialist (RS), but the CE will lead the process.

c. CE Responsibilities. The CE is responsible for recognizing this dual track potential and for making the VR referral during the nurse intervention phase. It is recommended that the CE discuss this potential with both the SN and the RS before making such a referral. Ultimately, it is the CE's responsibility, in coordination with the SN and RS, for keeping both the FN and the RC within their roles and achieving the best outcome.

Once a case has been accepted for both types of intervention, the CE should send out a letter to the claimant and EA about this dual track approach, explaining the roles of both the FN and the RC as well as the claimant's own responsibilities in cooperating with this approach.

12. Medical Management. A variety of medical issues arise while a case is in nurse intervention. It is the CE's responsibility to be aware of these issues and to take prompt action on those requiring further clarification and CE response. While the FN will be actively involved in working with the claimant, the physician and the EA, the ultimate responsibility of managing the direction of the case continues to rest with the CE. It is important, therefore, for the CE to utilize the services of the FN in a constructive way, keeping in mind that the ultimate goal of nurse intervention is to minimize the length and extent of disability whenever possible.

a. Initial Actions. The CE has two primary medical intervention options during Nurse Intervention. One is a letter to the claimant's treating physician, and the other is a second opinion referral. Also, the CE may consult with the District Medical Advisor (DMA) or SN regarding diagnosis, length of disability, proposed treatment plan, or any medically-related issue for the purpose of gaining a better understanding of the nature of injury and to help formulate the next appropriate intervention. Any or all of these types of medical interventions may be taken simultaneously while a FN is working on a case.

The timing of these actions is important. First, the CE must recognize that there is a need for such an intervention, and then the CE must determine the best type of intervention. For example, if a treating physician notes a change in diagnosis or extends disability without rationale, the CE should recognize these as obstacles or barriers and take prompt action to determine whether that change in diagnosis is medically supported, whether it is related to the accepted mechanism of injury, and then obtain information on the probable outcome. Other red flags requiring CE medical intervention action are continued extensions for physical therapy without

clear goals or direction, as well as multiple, concurrent medical conditions which may further complicate a successful return to work.

The type of intervention depends upon the CE's determination of the quickest resolution to these obstacles, knowledge of the claimant's EA's ability to reemploy injured workers in various capacities, as well as awareness of claimant motivation. The FN may also make recommendations.

(1) Treating Physician. The claimant's treating physician generally has the most knowledge about the claimant's work-related medical condition, as well as any non-work related medical issues, and the attending physician is the one who is recommending specific treatment options for the claimant. When any concerns or issues are identified by the CE or raised by the FN, the CE has two options during the nurse intervention period.

(a) The CE can issue a targeted letter to the claimant's treating physician specifically requesting rationalized medical information in order to clarify any medical issues. Any letter should be tailored to fit the specifics of the case, identifying the specific medical issues or concerns and seeking clear responses in order to obtain the best results.

(b) The CE can direct the FN to obtain the specific information from the physician. Since the FN should have a working relationship with the claimant's physician, in many instances he or she can obtain the clarifying or necessary information in a more expedient manner.

(2) Second Opinion Referral. The CE may opt to obtain a second opinion examination during Nurse Intervention. When possible, it is recommended to make this referral while the FN is still assigned to the case so that upon receipt of the report the FN can assist with the medical information obtained. For example, if the second opinion physician recommended surgery or a different treatment modality, the FN can be instrumental in coordinating pre- and post-operative care for the claimant.

(3) DMA Referrals. The DMA can be a valuable resource for the CE to help better understand a claimant's medical condition, treatment proposed, and potential outcomes with respect to whether a claimant may be able to return to some form of gainful employment. The DMA can provide an opinion with regard to the appropriateness of certain types of surgical requests and, if necessary, advise whether further information is required, or whether a second opinion might be necessary.

(4) Consultations with the SN. The SN is uniquely qualified to assist CEs with medical issues that arise during the nurse intervention process. The SN may help CEs gain a better understanding of the FN reports and recommendations offered, and then to direct FNs to obtain clarifying information. The SN may also help the CEs formulate appropriate questions

to the attending or second opinion physicians.

SNs are able to assist the CEs in understanding the particular treatment being recommended or undertaken by a claimant. The SN may also assist with determining whether a functional capacity evaluation (FCE), a consultation with a specialist, or a home health aide would be necessary, or whether more information is required. Together with the CE, the SN can help to explore the medical intervention options in order to maximize early recovery and return to work.

b. Secondary Actions. After a response has been received from the attending physician or a second opinion report has been received, the CE is responsible for reviewing the report and formulating the next course of action. The CE should send a copy of the report to the FN, if he or she does not already have it, and discuss the next course of action. The SN may also be involved if necessary. In problematic cases it may be advisable to conduct a conference call with the FN. Such a call may also include the SN, claimant, and/or EA to discuss the evaluation results and potential for return to employment.

It is essential that the CE take prompt follow-up action on these medical interventions, since the FN has a limited assignment period on the case. It may be necessary to extend the FN's time on the case, but that can best be determined if the CE reviews the medical evidence promptly and discusses the findings with the FN and/or SN. The sooner the next course of action is determined, the greater the likelihood that the claimant obtains the necessary treatment and achieves a faster recovery so that he/she may return to work. If a claimant returns to work while the FN is still assigned to the case, the FN may assist the claimant with certain post-employment services, which generally help the claimant remain at work.

13. Best Practices. The CE and FN work together as a team to assist the claimant in the earliest and best recovery possible, as well as a successful return to work. The goal is for the claimant to return to full-duty work within one year from the date of injury (during the period of retention rights set forth in 5 U.S.C. 8151). Timely and appropriate disability management, good CE judgment, and directed action make the likelihood of achieving this goal more realistic. Adjudication of a claim at the first opportunity, prompt payment of compensation to a claimant who is disabled, and early nurse referrals greatly assist in this endeavor.

Once a FN has been assigned to an accepted case, there are some practices that a CE should utilize in order to obtain the targeted outcome. Some of these best practices are identified below, but each case is unique and every intervention action should be crafted to the specific circumstances of that particular case. All of these practices involve consistent and timely communication between the FN and the CE, timely CE response to FN recommendations, and identification of medical obstacles as well as prompt intervention with a non-cooperative claimant.

a. Conference Calls. During the nurse intervention phase, CEs will find that conference calls with all parties are most useful. These multi-party calls can involve the SN, the claimant, the EA and the FN. Depending upon the stage of recovery, the CE may initiate a conference call with all of these parties at the same time. When a job offer is found unsuitable, a conference call with the EA, the claimant and FN often effectively defines the deficiency and the result is a suitable offer. If a claimant has been out of work for a longer period of time, a conference call can help get the worker involved again with the EA and can be helpful in addressing fears about returning to work. The CE may ask the FN to coordinate the scheduling of the conference with all parties, which will enable the CE leading the conference to focus on the direction and goals. See PM 2-0600-12 for more information on conferences during Disability Management.

b. Surgery. If a surgery has been authorized, the FN may assist in both the pre- and post-operative management of the medical care for the claimant. The FN may attend the pre-operative appointment, assist the medical providers with billing, and help the claimant with recovery coordination and support. The CE can rely on the FN to coordinate securing any prescribed durable medical equipment and home health aides, if necessary. Results are best attained when the CE is available to the FN, who may have authorization and compensation questions. After surgery and sufficient recovery, the CE should direct the FN to obtain work restrictions and to make contact with the EA for a job offer. A pre-surgery conference call with the claimant and the FN is a good tool, as it provides useful information to the claimant, allows the CE to better identify intervention points based on anticipated stages of recovery, and often facilitates an earlier return to work because it sets the stage for what the claimant may expect from OWCP post-surgery.

c. Extensions. A FN should be aware of the time frames within which he or she is working and, if an extension is necessary, the FN should request such in advance. The CE should be aware of what the FN has been accomplishing and the current status, so that when an extension is requested, the CE will know whether it should be authorized. Extensions are most useful when a return to work is imminent or there are work restrictions in file and the EA is willing and able to accommodate work limitations. The CE should be reasonably assured that a return to work will occur

and should be clear about the reasons for, and the goals of, the extension. If it is not for an imminent return to work, then an extension should only be authorized to finalize some work restrictions or to obtain some other clearly defined goal.

d. Recurrences. To be most effective, a FN referral should be made when a recurrence of disability is accepted. Such a referral should be treated similar to an initial referral for FN services. There should be a targeted goal outlined by the CE to the FN, and the CE should work closely with the FN to attain these goals: recovery and an early return to work. The CE may want to discuss the selection of the FN assigned with the SN prior to referral, since the reassignment of the same FN that had been assigned prior to the recurrence may be appropriate based on that FN's background on the case and rapport previously established.

e. Partial Disability. The CE may make a FN referral when a claimant has already returned to work in a light-duty capacity. In order for nurse intervention to be successful, the CE should identify the referral goal as maintaining the claimant at work or attempting to increase the claimant's work tolerances. The FN may arrange for an FCE and for the treating physician the opportunity to review the results of the FCE. The FN can also help to coordinate a treatment plan which greatly encourages an increase in work tolerance limitations. The EA should be willing to accommodate any changes in work restrictions and be generally supportive of the FN or RC in facilitating an ergonomic assessment, if needed, and the purchase of ergonomic equipment. The CE, however, should be actively involved in this activity and work closely with the FN on the goal of increasing work hours and activities.

f. Catastrophic Cases. Due to the complexity and long-term nature of catastrophic cases, CEs should make a FN referral as soon as the case is accepted. The SN, CE and FN (and RC if assigned) should work together closely for the best results. Often the claimant and family members are involved in such cases. There are often multiple medical or nursing facilities, physicians, therapists, attendants and durable medical equipment providers involved in the care of the claimant, all of which require billing and authorization actions in addition to the coordinated care of the claimant. CEs should work closely with the SN, who is instrumental in directing the FN as to what our program provides in these situations.

Close communication and collaboration is the key to working through the multiple phases of a catastrophic claim. Hospital team conferences may be useful, and the CE and FN should participate. It is often a good idea for the SN to also participate in these conferences in order to provide appropriate guidance about FECA coverage and the benefits available. Often, alternative living facilities or intensive home health care is needed after the initial acute phase of care. CEs should rely on the expertise of the FN and SN to assist in locating the best and most cost-effective provider available to the claimant. Whenever possible, the CE should be cognizant of the possibility that even a severely injured claimant may be able to perform work activities, and then to consider a vocational rehabilitation referral when indicated.

2-0812 PERIODIC REVIEW OF DISABILITY CASES

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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 continuing entitlement to compensation as well as the nature of that entitlement. Monitoring of death claims is addressed in FECA PM 2-0700.

Payment on the periodic roll is an efficient method of ensuring regular payment of compensation to those with long-term compensable disabilities. In all periodic roll cases, it remains the responsibility of the Claims Examiner (CE) to ensure that evidence remains current in the case, that all suitable medical care is provided, and that appropriate use is made of nursing and rehabilitation services. Quality case management, with active monitoring of the progress of the case, should be utilized to obtain the best possible outcome and a return to employment where at all feasible.

2-0812-2 Statutory Provisions

2. Statutory Provisions. When a case has been accepted, the claimant is entitled to compensation benefits and medical treatment for the medical condition(s) 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.

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, schedule award entitlement is payable consecutively, but not concurrently, with an award for wage loss due to the same injury.

c. Section 5 U.S.C. 8111 provides for additional compensation for the service of an attendant where required; after January 4, 1999, this is generally paid as a medical expense pursuant to 5 U.S.C. 8103.

2-0812-3 Burden of Proof in Continuing or Terminating Benefits

3. Burden of Proof for Terminating Benefits. Having accepted a claim and initiated payments, the OWCP 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. However, failure to report for or cooperate with an OWCP directed medical examination would constitute grounds for suspension of benefits 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).

2-0812-4 Placement and Monitoring of Claims and Periodic Roll

4. Placement and Monitoring of Claims on the Periodic Roll. Where prolonged (over 90 days) or permanent disability is expected, compensation for wage loss should be paid on the periodic roll. After payment has begun, the CE is responsible for obtaining medical and non-medical evidence to determine continued entitlement. The CE is responsible for periodic review of active cases to ensure that payments are correct and that continuing entitlement is substantiated in the file.

a. Placement. When periodic roll payments are initiated, the CE should advise the claimant by Form CA-1049 or equivalent narrative letter. The letter should notify the claimant of the conditions for termination of benefits without prior notice and the requirement that employment be reported. A copy of the notice should be sent to the employing agency regardless of the claimant's current employment status.

b. Monitoring. The CE will document the Periodic Entitlement Review (PER) annually, and 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.

2-0812-5 Definition and Frequency of Reviews.

5. Definition and Frequency of Reviews. All cases on the periodic roll require completion of Forms CA-1032 and SSA-581 on a yearly basis. The office generates and mails Form CA-1032 and Form CA-935 (with enclosure SSA-581) to claimants. The CE should then review each case after 30 days has elapsed and complete the PER.

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 require medical review once a year.

b. PW. Cases in which payments are being made for a loss of wage-earning capacity require medical review every two years.

c. PN. Cases in which the CE has determined, and the Supervisory Claims Examiner (SCE) has verified, that no wage-earning capacity exists require medical review every three years.

d. 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, the case may be reviewed more frequently.

While reviewing Forms CA-1032 and SSA-581, along with the medical and factual evidence, the CE should update the PER accordingly. The factual and medical elements of the review are outlined in detail in the following paragraphs.

2-0812-6 Medical Elements of Review

6. Medical Elements of Review. Medical evidence should be obtained in accordance with the case status, as noted in paragraph 5 above, in order to determine the progress of the employment-related condition and the extent of impairment resulting from this condition.

General procedures for obtaining medical evidence are contained in FECA PM 2-0810. Where adequate medical reports are not received at intervals reasonable to the particular case, it is the CE's responsibility to obtain them or to make an appropriate referral 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, 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 as described in paragraph 5 above.

If appropriate, specific questions should be addressed to the physician regarding whether a temporary aggravation has resolved or whether the aggravation has caused a material change in the pre-existing/underlying condition; whether the claimant's physical condition permits a return to the job held at time of injury or to a restrictive position; or whether the claimant would be a candidate for vocational rehabilitation. A copy of a current and accurate SOAF should be enclosed if it would assist the physician with providing a response.

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) Results of recent objective testing.

(3) Physical examination findings.

(4) The diagnosis of any conditions present.

(5) A well reasoned medical opinion supported by the physical findings and objective testing as to whether the current condition(s) is related to the employment.

(6) The claimant's work restrictions, including a completed Form OWCP-5 if applicable.

(7) The type and frequency of medical treatment being provided or recommended.

b. Follow Up Actions.

(1) If sufficient medical evidence is in file, the CE should review the reports to determine whether disability is related to the employment injury; whether disability for the job held at the time of injury continues; whether appropriate medical treatment is being given; and whether the case should be expanded to include consequential conditions. If partial disability is indicated, the CE should determine whether the claimant's work limitations permit any employment. If so, the CE should consider referring the case for vocational rehabilitation services (see FECA PM 2-0813).

(2) If a medical report is not received within the specified time (30-60 days should be considered reasonable) or is not responsive to the questions asked, the CE may write to the physician for more information.

The CE may also direct the claimant to undergo an examination by a second opinion specialist. If the CE determines that a conflict of opinion exists between the claimant's attending physician and the second opinion specialist concerning the extent and work-relatedness of disability, the conflict must be resolved by a referee specialist. The OWCP should make an appointment for the examination. The notification to the claimant should include the warning that under 5 U.S.C. 8123(d) benefits may be suspended for failure to report for examination. Note that the sanctions outlined in Section 8123(d) may be invoked only in connection with a specific appointment (see FECA PM 2-0810).

c. Changes in Medical Status. The CE should take action based on the weight of the medical evidence as follows:

(1) Where injury-related disability has ceased, notify the claimant of proposed termination of benefits (see FECA PM 2-1400). The OWCP has the burden of proof to justify the termination of benefits by positive and specific evidence that injury-related disability has ceased. The inadequacy or absence of a report in support of continuing benefits is not sufficient to support termination.

(2) Where total disability has ceased but permanent residuals of the employment-related injury remain, which prevent the employee from performing the regular duties of his or her date of injury position, action should be taken to reemploy the individual through vocational rehabilitation and placement with the previous employer. This would be followed by a loss of wage-earning capacity decision if appropriate.

(3) Where the claimant has no earning capacity, prepare a memorandum to file for certification by the SCE to establish placement in PN status. See

Exhibit 1.

2-0812-7 Attendant Allowance

7. Attendant Allowance. As part of the medical review of the case, the CE should also determine whether an attendant allowance is being paid, and if so, whether continuation of those payments is appropriate.

20 CFR 10.314 allows payment for services of an attendant where it is medically documented that the claimant requires assistance to care for personal needs such as bathing, dressing, eating, etc. Such services are paid as a medical expense under 5 U.S.C. 8103; 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 of the Federal Regulations, an attendant allowance was paid directly to the claimant. Any such allowance approved prior to January 1999 will continue to be paid to the claimant until the need for the attendant ceases. As part of the attendant allowance review, the CE should consider the following:

a. 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.

b. Concurrent Receipt of Other Federal Payments. An attendant allowance is payable even though the claimant is receiving salary or sick or annual leave pay. A claimant who has elected benefits under the Civil Service Retirement System (CSRS) or the Federal Employees' Retirement System (FERS) may not receive an attendant allowance except for periods concurrent with payment of a schedule award by the OWCP.

c. 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.

2-0812-8 Factual Elements of Review

8. Factual Elements of Review. Factual evidence is obtained primarily from Form CA-1032. Potential issues raised by Form CA-1032 and case review include:

a. Employment and earnings information. This is requested from the claimant on Form CA-1032. Other sources include:

(1) The Social Security Administration (SSA), which should be asked to submit earnings information via Form CA-1036 when information of any kind

is received suggesting possible employment or earnings.

(2) A new employer, who may be asked to complete Form CA-1027 or an equivalent request 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.

(3) 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 entitlement to compensation. Additional guidance on developing earnings information is provided in paragraphs 9 and 10 below.

b. Dependent information. A claimant's entitlement to augmented compensation is usually determined from information supplied by the claimant on Form CA-1032, although it may come in narrative form. Other sources include:

(1) Form CA-1615 should be released to the claimant for completion shortly before a child reaches the age of 18 if augmented compensation is being paid solely on the basis of a dependent whose dependency status rests on the "student" requirement. A request should be released for completion on 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." Form CA-1618 may be used for ongoing verification.

(2) If the claimant has a dependent over the age of 18 due to the fact that the dependent is incapable of self support, the CE must review the case record to determine continued eligibility. The medical evidence in the file pertaining to the dependent should reflect that the dependent is incapable of self-support by reason of a mental or physical disability. A claimant is not entitled to augmented benefits for a child over 18 due to the child's inability to obtain employment due to economic conditions, lack of job skills, etc.

(3) Investigation, as outlined in FECA PM 2-0402, should be considered when evidence concerning the existence of eligible dependents is in question and entitlement cannot be determined adequately by the written evidence.

The CE is responsible for making any changes in payments when necessary.

c. Dual benefits. Receipt of benefits from other Federal agencies such as the Office of Personnel Management (OPM), Social Security Administration (SSA) or the

Department of Veterans Affairs (VA) may require an election of benefits or an offset. Other benefits such as separation incentives or buyouts may also require an offset of compensation benefits. See FECA PM 2-1000 for a detailed discussion of dual benefits.

The CE should review the file carefully if the claimant is 62 years or older and is under the FERS, since a FERS offset may be required. An offset is not required for CSRS benefits. If the CE cannot determine what retirement system the claimant is under, the CE should send a letter to the claimant and to OPM to request information.

If the claimant is receiving benefits from the VA for the same injury for which FECA benefits are being paid, the CE should send Form CA-1019 to the VA. If the claimant's award from the VA has increased as a result of the injury, the claimant must make an election between FECA benefits and the increased VA benefits.

d. Third party settlements. The CE should refer any cases in which settlements have been newly made to the Solicitor's Office as appropriate.

e. Fraud and felony conviction. If the claimant is imprisoned while receiving compensation, benefits should be adjusted or terminated, as appropriate. If a claimant is convicted of fraud in connection with the application for or receipt of benefits under the FECA, 5 U.S.C. 8148(a) requires termination of all future benefits, including medical benefits. If a claimant is imprisoned based on a felony conviction unrelated to the FECA claim, 5 U.S.C. 8148(b) requires suspension of benefits to the claimant, but allows payment of benefits to eligible dependents (calculated under the percentages applicable to death benefits under 5 U.S.C. 8133) during the time that the claimant is imprisoned. See FECA PM 2-1400 for a more detailed discussion of these issues.

f. Address Changes. If the claimant has provided a different address the CE should update the case record in the case management system.

2-0812-9 Reports of Earnings

9. 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. Form CA-1032, along with the enclosure to Form CA-935 (Form SSA-581), must be completed at least annually by claimants who are on the periodic roll or on the daily roll for more than one year. 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 or volunteer employment. See William H. Higgins, 34 ECAB 833 (1983) and Howard M. Sprayberry, 36 ECAB 115 (1984). The fact that business expenses may outweigh income does not excuse the claimant from reporting the earnings. See William E. Steadman, 38 ECAB 688 (1987).

If a completed and signed Form CA-1032 is not received within 30 days, compensation benefits should be suspended. See paragraph 10(b) for further direction if a completed Form CA-1032 is not received.

If Form SSA-581 is not signed and returned after a second request is made, and there is some indication in the file that the claimant may have earnings or work activity, the case may be referred to the Office of Inspector General (OIG) for investigation to determine if the claimant has in fact earned wages for the period under consideration. If so, the CE may invoke forfeiture proceedings as described in paragraph 11. Benefits may not be suspended for failure to complete Form SSA-581, however, as authorization to obtain reports from SSA is not a requirement for receipt of compensation.

b. Report from the Social Security Administration (SSA). When information of any kind is received suggesting possible employment or earnings, the CE should release Form CA-1036 to SSA in cases where compensation is being paid on the periodic roll for total disability. Based on the circumstances in the case, it may also be necessary to send the Form CA-1036 to SSA in cases where compensation is being paid based on a loss of wage-earning capacity. Form CA-1036 need not be sent every year in every case, but should be sent when there is evidence of earnings that requires further development. The following steps should be taken to obtain wage information from SSA:

(1) Form CA-1036 must be accompanied by a signed release from the claimant on Form SSA-581. The CE should use the most recent Form SSA-581 completed by the claimant. Form SSA-581 is valid for only 60 days from the date signed by the claimant; hence, the CE should check the date the SSA-581 was signed before releasing the CA-1036. If the SSA-581 is older than 60 days, the CE must reissue a CA-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.

(3) If the amount of earnings is needed, specify this in the request 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.

(4) Because of a 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 information is truly needed and that the request does not cover a longer period than necessary for the proper handling of the claim. Particular care should be exercised where the request concerns a period in excess of five years. The request should not include any period for which information has previously been requested from SSA.

(6) If the names and addresses of employers are needed, specify this in the request and indicate the period for which the information is requested. The names and addresses of the employers are obtained from a record other than that which reflects the earnings. OWCP must reimburse SSA for the cost of assembling this information and transcribing it. Supplying the names and addresses of the employers will approximately double the costs; therefore, the names and addresses of the employers should be requested only when a clear need for this information exists.

(7) The request should contain the signature of the CE 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.

c. Report of Self-Employment. When OWCP receives evidence that the claimant owns or is a partner in his or her own business, or is an officer in a corporation, the CE should request additional information from the claimant concerning the specific nature of the business and his/her involvement therein. This request should be made by narrative letter and questions should specifically address the circumstances of the case. The letter should include a reference to the Secretary's authority to require such information and the penalties associated with false reporting (the references contained in Form CA-1032 may be used). The letter should ask the claimant to sign and date his/her response, certifying the accuracy of the information given. Exhibit 2 provides sample questions which may be used as appropriate to obtain the information needed.

2-0812-10 Actions on Reports of Earnings and Dependents

10. 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. Generally, 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, Form 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 2-0814). 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 information in the file and payment reports to ensure that benefits are being paid at the proper compensation rate; adjustments should be made as necessary.

b. Suspension of Compensation. OWCP 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. See 20 CFR §10.528. Likewise, entitlement to augmented compensation may be suspended (i.e., compensation may be reduced from 3/4 to 2/3) if the OWCP does not receive a timely response to a request for information concerning eligible dependents. See 20 CFR §10.536.

(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).

(a) If extenuating circumstances are not present and benefits are being paid for other than a schedule award, the CE should act to suspend compensation entirely since no report of either earnings or dependents (if any) will have been received.

If extenuating circumstances are not present and a schedule award is being paid, only the entitlement based on dependents will be at issue. The CE need not act to suspend augmented compensation if some recent communication (a letter from the claimant, or a completed Form CA-1618, for example) appears in the file showing that the claimant has at least one eligible dependent.

(b) If extenuating circumstances apply or the form is received but not substantially completed, the CE should advise the claimant of the

information which is still required and indicate that, unless a fully completed Form CA-1032 is received within 30 days, benefits will be suspended. See Exhibit 3.

(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. The decision should include appeal rights. See Exhibits 4 and 5.

(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 life insurance (LI) 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 effective date of suspension where the evidence submitted supports the payment of benefits, and should include retroactive deductions for HB and/or LI premiums, as needed.

2-0812-11 Forfeiture

11. Forfeiture. Section 8106(b) of the FECA provides that compensation may be forfeited for failure to report earnings.

a. Circumstances under which Forfeiture may be Applied.

(1) 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. See Joseph M. Popp, 48 ECAB 624 (1997).

(2) 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.

(3) 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.

However, it should be noted that the instructions for filling out the Form CA-1032 are quite specific and notify appellant to report all employment activities, including volunteer work. The ECAB has repeatedly held that the OWCP Form CA-1032, as signed and dated by an employee receiving compensation, may constitute substantial evidence as to what the employee "knew" with regard to the requirement to report his or her employment activities to the OWCP.

See the following ECAB cases for more guidance in this area:
A.A., Docket No. 07-877 (issued October 17, 2007) (employee knowingly failed to report her employment earnings on the CA-1032 she submitted);
S.R., Docket No. 07-618 (issued July 10, 2007) (employee knowingly failed to report work activities and earnings from an eBay account);
David P. Bjornson, Docket No. 04-1339 (issued March 21, 2005) ("…appellant's signing of certification clauses on the CA-1032 form provides persuasive evidence that he "knowingly" understated his earnings and employment information");
John A. Graham, Docket No. 04-759 (issued September 30, 2004) (failure to fully report his earnings to OWCP was found to be a "knowing omission" by appellant);
Daniel J. Baladez, Docket No. 01-439 (issued June 4, 2003) (employee knowingly failed to report his earnings from his "hobby");
John Lombardo, Docket No. 01-814 (issued July 1, 2002) (employee knowingly failed to provided information on his intermittent work activities);
Francisco Serrano, 40 ECAB 824 (1989) (the employee knowingly failed to provide information on his employment in his brother's company);
Monroe E. Hartzog, 40 ECAB 322 (1988) (the employee knowingly failed to report his employment in a family business selling mobile homes);
Harry S. Renkert, 39 ECAB 1142 (1988) (the employee knowingly failed to report his employment as a fishing guide); and
Jesse Meredith, Jr., 38 ECAB 575 (1987) (the employee knowingly failed to report his earnings as a substitute teacher).

(4) 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 2-0814. If the claimant simply fails to make a report, benefits are suspended as described in paragraph 10(b).

(5) 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.

b. Advising the Claimant. When the evidence shows that the claimant had earnings and knowingly did not report them on Form CA-1032, the Senior Claims Examiner should prepare a formal decision declaring the compensation forfeit and an overpayment. The period of forfeiture is as follows:

(1) If Form CA-1032 was issued, the forfeiture applies to the entire period covered by the form (15 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.

(2) If Form CA-1032 was not issued for the period during which the claimant worked or had earnings while receiving compensation, the period of forfeiture is limited to the period that the claimant actually worked and did not report earnings. See Curtis D. Humphrey, 47 ECAB 553 (1996).

An overpayment decision should be released with the formal decision, finding the claimant to be with fault in creating the overpayment, since the claimant failed to furnish information which he or she should have known to be material.

(3) Prior to declaring the forfeiture, action should be taken on the issue of entitlement. If injury-related disability does not continue, a notice of proposed termination should be issued simultaneously with the forfeiture decision. If work-related disability is established, the claimant's wage-earning capacity should be determined, based on actual earnings or a constructed loss of wage-earning capacity (LWEC) rating, and benefits should be reduced accordingly.

Generally, a forfeiture decision should not be released until the entitlement issue is fully resolved; however, based on the circumstances in a particular case, proceeding with forfeiture prior to completely resolving entitlement may be appropriate.

If for some reason the entitlement issue cannot be addressed in a timely manner (e.g., as a result of investigation and/or litigation), a status report should be provided to the District Director (DD) or his or her designee until

the entitlement issue is resolved. In these cases, and any others which have 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.

c. Fiscal Actions. The period of forfeiture should be calculated as outlined earlier in this section. Once the overpayment has been declared and after due process requirements have been satisfied, the OWCP should recover the forfeited amount in the same manner as any other overpayment.

d. 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 Periodic Entitlement Review (PER) Codes

12. Periodic Entitlement Review (PER) Codes. Codes used for documenting periodic entitlement review actions and Periodic Roll Management (PRM) resolutions have changed over time. PER actions are now documented by the CE in the Entitlement Review application in Disability Management (DM). PER action codes are noted below and in Exhibit 6. These codes are entered in the Entitlement Review application to document development undertaken and the outcome of the periodic review.

a. PER Development Codes are entered in the PER record when further action or review is required prior to closing the PER. If the CE has to develop the case for any reason, the CE should place the PER record into a development status by selecting an appropriate code as outlined below.

AI	Payment/Entitlement Adjustment in Development
NI	PN Memo in Development
SI	Payment/Entitlement Suspension in Development
TI	Payment/Entitlement Termination in Development
UD	Under Development

b. PER Closure Codes are entered in the PER record when the periodic review is complete. The evidence in the case file should substantiate the code selected as

outlined below:

EA Payment/Entitlement Adjustment

ES Payment/Entitlement Suspension

ET Payment/Entitlement Termination

NC No Payment/Entitlement Change

PN PN Memo

The PER action codes entered into the Entitlement Review application indicate development undertaken and the result of the entitlement review. Development actions taken as a result of the PER review should also typically be documented in the DM Tracking application in Disability Management, especially if the development is medical in nature. Some final actions taken as a result of the PER review should also be entered into DM Tracking, such as termination and suspension actions.

2-0812-13 Disability Management (DM) Status Codes

13. Disability Management (DM) Status Codes. DM codes are used to document actions taken during disability management, such as sending a letter to a physician or scheduling a second opinion examination. DM codes are also used to document a "resolution" in a PRM case, such as a termination of benefits or a finding that the evidence of file substantiates the current level of entitlement.

DM codes are used to document actions that may coincide with the development undertaken as the result of a PER review or a final PER action. Note, however, that a PER action or closure code will not always coincide with a DM status code. The PER application is distinct from DM Tracking, each serving a unique purpose.

There are DM status codes to reflect reduction of compensation, suspension of compensation, termination of compensation, and no change in entitlement. Not all DM status codes however count as a successful PRM resolution.

For a complete explanation of DM coding, see PM 2-0601. DM status codes used for documenting PRM resolutions are noted below and in Exhibit 7.

a. DM Status Codes for PRM Resolutions Involving Reduction of Compensation.

(1) CAE - - RTW with LWEC. Used when the CE issues a formal loss of

wage-earning capacity decision when a claimant 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 actual earnings and an actual wage loss.

(2) CLW - - Constructed LWEC. Used when the CE issues a formal loss of wage-earning capacity decision based on a selected position identified through Vocational Rehabilitation.

(3) CCL - - LWEC Modification. Used when the CE issues a formal decision modifying a prior LWEC decision that results in cost savings.

b. DM Status Codes for PRM Resolutions Involving Suspension of Compensation.

(1) SUC - - Suspension 5 USC 8113. Used when the CE issues a suspension for failure to cooperate with vocational rehabilitation efforts.

(2) SUM - - Suspension 5 USC 8123. Used when the CE issues a suspension for obstruction of an office directed medical examination (e.g. second opinion examination or referee examination).

c. DM Status Codes for PRM Resolutions Involving Termination of Compensation.

(1) CCO - - Terminated, no continuing injury related disability. Used when the CE issues a decision terminating medical and/or monetary benefits because the medical evidence in file demonstrates that the claimant no longer suffers from continuing residuals causally related to the accepted work injury. Also used when monetary benefits are terminated via a formal decision because the claimant's work-related disability has ceased.

(2) CFC - - Terminated, Fraud Conviction. Used when the claimant is convicted of fraud against the OWCP and/or the United States Government.

(3) CFF, NFF, RFF - - RTW, no LWEC. Used when the IW returns to full duties of the DOI position or a pre-established LWEC job. NFF is used if the nurse was involved with the return to work effort, and RFF is used if the rehabilitation specialist/counselor was involved with the return to work effort. CFF is used if neither the nurse nor rehab was involved in the return to work effort.

(4) CNL - - RTW, not DOI job with 0% LWEC decision. Used when the CE issues a formal loss of wage-earning capacity decision when a claimant 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 no resulting wage loss.

(5) CSA - - Refused suitable work. Used when the CE issues a formal decision under Section 8106(c)(2) of the FECA because the claimant refused suitable employment.

(6) CSB - - Compensation not claimed. Used when a claimant elects other benefits (such as OPM) instead of receiving OWCP compensation, or chooses to no longer receive OWCP benefits for some other reason.

d. DM Status Code for PRM Resolution with No Change in Compensation.

(1) PCR - - No change in entitlement after review. The medical and factual evidence in the file should clearly reflect this finding, and the CE should document this finding with a memo to the file. See Exhibit 8 for a sample. If the CE is simultaneously recommending that the case status be changed to PN, the same memo can be used. Refer back to Exhibit 1 and notice the wording at the bottom of the PN memo.

Note - The CE can use this code in each case only once during a 5 year period.

e. DM Status Codes that are Not Counted as PRM Resolutions.

(1) CPN - - Permanent total disability decision. Used when the CE has determined that the claimant has no wage-earning capacity. This is documented by a memo to file. See Exhibit 1.

(2) CRC - - Reduction under 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) CRL - - Recurrence, LWEC Modification (TTD). Used when the claimant is receiving compensation for a loss of wage-earning capacity (LWEC) and that decision is formally modified resulting in placement on the periodic roll for total disability. After the LWEC is modified, the entry of this code will close the PRM DM record, and then allow the creation of a new Quality Case Management (QCM) DM record.

(4) DEA - - Death of Claimant. Used when a claimant dies. The case should be taken out of PR/PW/PN status and removed from the DM universe.

(5) SUE - - Suspension for no CA-1032. Used by the CE when the claimant

fails to complete and return Form CA-1032.

2-0812 Exhibit 1: PN Memo Example

Subject: PN Memorandum to the File
File Number: 123456789
Employee: Claimant Name

Issue: The issue is whether the case should be placed in a "PN" status since the claimant has no wage-earning capacity or re-employment potential for the indefinite future.

Requirements for Entitlement: In order for the case status to be updated to PN, the medical evidence must demonstrate that the accepted medical condition(s) has reached maximum healing or that no further improvement is anticipated. Additionally, the file must reflect that the claimant has no wage-earning capacity due to the severity of the claimant's medical condition and/or vocational prospects in the claimant's commuting area.

Background: The claimant, born 03/08/1944, was employed as Border Patrol Agent with the U.S. Department of Homeland Security. On 07/25/2002, the claimant was injured when he lifted a tire from the bottom of a stack and then slipped and fell, hitting his head. The claimant was unconscious for 45 minutes and hospitalized for several weeks. The claim was accepted for a herniated disc L4/5 without myelopathy, cervical herniated disc C4/5 and closed head injury. The claimant has not returned to work. He has had two work related surgeries for his cervical condition and a lumbar fusion.

A request for an updated medical report was sent to the attending physician, Dr. John, on 06/10/2009. No response was received so it was determined that a second opinion evaluation was necessary. The appointment was scheduled for 08/21/2009 with Dr. Henry, a neurologist. Prior to the appointment, the physician was provided with a copy of the medical records on file, a Statement of Accepted Facts, and specific questions to answer. Dr. Henry provided a thorough and well rationalized report. He opined that the claimant continues to suffer from a herniated disc in the cervical spine and failed back syndrome as a result of the spinal surgeries. Dr. Henry also indicated that the claimant continues to have severe cognitive deficits from the closed head injury. He may not return to work and continues to have severe physical restrictions as indicated on the OWCP-5.

Basis for Decision: Dr. Henry provided a well-rationalized, comprehensive opinion, including objective findings, and his opinion was based on an accurate history of the work injury. He provided a substantial, detailed discussion of his medical opinion. Based on Dr. Henry's report of 08/21/2009, the claimant is totally disabled due to the work injury, and his condition is not expected to improve.

Recommendation: The employee's wage-earning capacity has been considered, including the following factors: nature of injury, degree of impairment, usual employment, age, qualifications for other employment and availability of suitable employment. The evidence of file establishes that the claimant remains totally disabled for all work and his condition is

not expected to improve. The case therefore should be placed in a PN status.

OPTION:

- ✓ A PCR code in Disability Management Tracking is also recommended as the claimant continues to be entitled to the current level of benefits.

_____
_____
Claims Examiner Supervisory Claims Examiner

2-0812 Exhibit 2: Sample Questions Regarding Self-Employment

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 not, 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 (FECA), 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 Form 1040, Schedule F or C and Schedule SE for that year.

CORPORATE OFFICERS, Continued

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 3: Sample Letter Where Form CA-1032 was Incomplete

Dear CLAIMANT NAME:

I am writing in follow up to the Form CA-1032 that was sent to you on DATE.

We received the CA-1032 that you signed on DATE; however, it was not completed properly as you failed to answer all the questions.

You must answer all "yes" or "no" questions. If a question does not require a "yes" or "no" and it does not apply, please so indicate with "N/A", not applicable.

You did not complete the **Certification** section of the form, which is Section H on page 5. Please certify your answers by completing this section appropriately. Please ensure that all items are completed, i.e. signature, date, street address with city, state and zip code, and telephone number.

This letter serves as a second and final request for you to fully complete and return to us the enclosed Form CA-1032. Please return this form to our office within 30 days from the date of this letter.

20 CFR 10.528 provides that individuals in receipt of compensation from the Office of Workers' Compensation Programs (OWCP) are required to periodically furnish certain information to the OWCP via Form CA-1032. This regulation further provides that individuals who refuse to furnish this information shall have their benefits suspended by the OWCP. Therefore, if you fail to submit the fully completed CA-1032 to this office within the requested time frame, your compensation benefits will be formally suspended until such time that you do submit this form.

You are reminded that providing false, fictitious, or fraudulent statements or representations on this form is a violation of federal law and may subject you to criminal or civil prosecution as well as forfeiture of benefits under the Federal Employees' Compensation Act.

If you have any questions, please contact our office.

Sincerely,

SENIOR CLAIMS EXAMINER

2-0812 Exhibit 4: 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 10.525(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 5: 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 10.536 of the OWCP's regulations states 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 6 – Periodic Entitlement Review (PER) Codes

Development Codes:

AI Payment/Entitlement Adjustment in Development

NI PN Memo in Development

SI Payment/Entitlement Suspension in Development

TI Payment/Entitlement Termination in Development

UD Under Development

Closure Codes:

EA Payment/Entitlement Adjustment

ES Payment/Entitlement Suspension

ET Payment/Entitlement Termination

NC No Payment/Entitlement Change

PN PN Memo

2-0812 Exhibit 7: Disability Management (DM) Status Codes for PRM Resolutions

RESOLUTION CODES:

Reduction of compensation:
CAE RTW with LWEC
CLW Constructed LWEC
CCL LWEC Modification (with reduction in compensation)

Suspension of compensation:
SUC Suspension 5 USC 8113 (rehabilitation non-cooperation)
SUM Suspension 5 USC 8123 (medical obstruction)

Termination of compensation:
CCO Terminated, no continuing injury-related disability
CFC Terminated, Fraud Conviction
CFF RTW – date of injury or pre-established LWEC job
CNL RTW, not DOI job with 0% LWEC decision
CSA Refused suitable work
CSB Compensation not claimed
NFF RTW with Nurse Assigned – date of injury or pre-established LWEC job
RFF RTW with Rehab Assigned – date of injury or pre-established LWEC job

Case reviewed, no change:
PCR No Change in entitlement after review
(Can only be used once during a 5 year period.)

Necessary codes, NOT counted as resolution:

CPN Permanent total disability decision (PN Memorandum to the File)
CRC Reduction 5 USC 8148(b) (felony incarceration)
CRL Recurrence, LWEC Modification (to TTD)
DEA Death of Claimant
SUE Suspension for no CA-1032

2-0812 Exhibit 8: PCR Memo Example

Subject: PCR Memorandum to File
File Number: 234567890
Employee: Claimant Name

Issue:
The issue is whether the claimant remains entitled to the current level of benefits establishing a PCR determination.

Requirements:
To be entitled to the present level of compensation benefits, current medical evidence must support ongoing entitlement and that no change or improvement is expected.

Background:
The claimant, born 07/22/1949, was employed as a Customer Service Supervisor with the U.S. Postal Service. On 03/14/2003, the claimant was injured when a book case shelf fell striking him on the right side of his head and his neck. A closed head injury and cervical herniated disc were accepted as work related. To date, the claimant has not returned to work.

Discussion of Evidence:
The most recent medical evidence on file from the attending physician, Dr. Smith, is dated 08/11/2008 and states that the claimant continues to suffer from cervical disc disorder and headaches and remains unable to work in any capacity.

The case was referred for a second opinion examination. The claimant saw Dr. James, a neurologist, on 11/05/09 to determine whether the accepted work-related conditions remain active, present, and disabling. Prior to the appointment, the physician was provided with a copy of the medical records on file, a Statement of Accepted Facts, and specific questions to answer. Dr. James opined that the claimant has cervical disc disorder due to the injury and is not be able to work. He further noted that no improvement is expected.

Basis for Decision:
Dr. James provided a comprehensive opinion based on a complete examination and an accurate history of the work injury, as well as objective findings and a discussion of his medical opinion. Dr. James' report is probative and well-reasoned and supports his opinion that the claimant remains totally disabled.

Conclusion:
Since the medical evidence in file supports ongoing entitlement to total disability benefits, the Disability Management Tracking record will be coded PCR for no entitlement change.

_____
Claims Examiner

2-0813 Vocational Rehabilitation Services

Table of Contents

1. Introduction, Purpose and Scope.

The Office of Workers' Compensation Programs (OWCP) emphasizes returning partially disabled workers to suitable employment through vocational rehabilitation efforts.

When it appears that the claimant's work-related injury will prevent a return to the job held on the date of injury (DOI), vocational rehabilitation services may be provided to assist the claimant in returning to the workforce in suitable employment. OWCP will make every reasonable effort to arrange for employment of a partially disabled worker, taking into consideration not only the effects of the work-related condition and any condition(s) pre-existing the injury, but also any medical condition(s) arising after the compensable injury. It is critical to understand that return to work placement efforts with the claimant's previous employer are an essential part of the vocational rehabilitation process and that vocational rehabilitation does not consist only of testing, training and outside employment. Such rehabilitation efforts will be directed initially to the employing agency (EA), but if reemployment with the agency is not possible, OWCP will help the worker secure employment with a new employer. This may require OWCP to sponsor vocational training, if needed, to furnish the worker with the necessary skills to obtain other employment.

The Federal Employees' Compensation Act (FECA) allows the Office to direct a claimant to undergo vocational rehabilitation and to reduce, prospectively, the claimant's monetary compensation for refusal to do so.

This chapter explains the procedures for referring partially disabled workers for vocational rehabilitation services and describes the services which may be provided.

This chapter also addresses related topics such as restoration rights with the Federal government, medical rehabilitation and the effects of substance abuse, and what actions to take if the claimant elects benefits from the Office of Personnel Management (OPM) during the rehabilitation effort.

Lastly, this chapter explains the procedures for reducing monetary compensation when the worker fails to cooperate with the vocational rehabilitation effort, obtains new employment, or is unable to secure new employment.

Further information about vocational rehabilitation can be found in the OWCP Procedure Manual (PM), Part 3, Rehabilitation.

2. Stautory, Regulatory and Program Requirements.

a. Statutory Requirements.

Section 8104 of the FECA provides that a permanently disabled individual may be directed to undergo vocational rehabilitation. The injured worker shall receive compensation while cooperating and participating in the rehabilitation process.

Section 8111 of the Act allows the Office to pay an individual undergoing vocational rehabilitation additional compensation necessary for maintenance, not to exceed $200 per month.

Section 8113 of the Act allows the Office to prospectively reduce compensation in accordance with a claimant's wage-earning capacity if he or she refuses, without good cause, to undergo vocational rehabilitation.

Section 8151 of the Act provides restoration rights for injured employees and is administered by the Office of Personnel Management.

b. Regulatory Requirements.

The Code of Federal Regulations discusses the vocational rehabilitation services provided at 20 C.F.R. §10.518. Additionally, the actions taken when the employee refuses to cooperate with vocational rehabilitation are discussed at 20 C.F.R. §10.519, and the method used for determining compensation after services are provided is discussed in 20 C.F.R. §10.520.

c. Program Requirements.

The Vocational Rehabilitation (VR) Program is comprised of a Rehabilitation Specialist (RS), who is located in the district office, and the Rehabilitation Counselor (RC), who is a certified counselor and works on a contractual basis in the district office's servicing area. The Claims Examiner (CE), with recommendations from the RS, is responsible for the management and overall direction of the case, even during the rehabilitation period.

A brief outline of the various roles is provided here, but more specific details pertaining to the different stages of vocational rehabilitation are provided throughout this chapter.

(1) The RS's responsibilities include, but are not limited to, the following: ensuring that there is a sufficient number of counselors to service the district office's needs; monitoring the RC's performance in correlation to both the contract specifications and the quality of service provided; assigning RCs to particular cases; reviewing RC reports for completeness and timeliness prior to authorizing payment of bills; communicating with the CEs regarding the cases assigned for VR services; relaying important or time sensitive information to the CEs so that action can be taken if needed; providing guidance to CEs on how to recognize when vocational services are necessary to assist the claimant with returning to work; serving as a vocational resource to the CEs; and providing solutions for return-to-work barriers in cases.

(2) The RC's responsibilities include, but are not limited to, the following: evaluating the claimant's vocational abilities and transferable skills; facilitating employment placement including with the previous employer; arranging for vocational testing and training; overseeing Occupational Rehabilitation Plans; conducting labor market surveys; formulating a vocational re-employment plan; assisting the claimant with job-seeking skills such as resume building and interview techniques; arranging for specialized ergonomic job modification services; and making recommendations to the RS and CE if a particular barrier is hindering the return-to-work effort.

(3) The CE's responsibilities include, but are not limited to, the following: referring appropriate cases for rehabilitation services; evaluating medical determinations in cases; responding to requests from the RS or RC; reviewing rehabilitation plans for medical suitability; issuing warning letters if non-cooperation occurs; and issuing notices of proposed actions and formal decisions pertaining to a claimant's entitlement to compensation.

3. <u>Compensation Entitlement during Vocational Rehabilitation</u>.

a. Compensation for Wage Loss. Section 8104 (b) of the FECA provides that an individual undergoing an OWCP-approved rehabilitation program is entitled to receive compensation at the rate for total disability, less any earnings received from employment which is not undertaken as a specific part of the rehabilitation program.

b. Retirement Benefits. A claimant may not receive vocational rehabilitation services simultaneously with retirement benefits from the Office of Personnel Management (OPM). However, a claimant may not use the retirement process to avoid the obligation to undergo vocational rehabilitation when directed by OWCP.

c. Schedule Awards. If a claimant requests a schedule award while participating in vocational rehabilitation, development of the award should proceed. Payment of the award, however, should usually be deferred until the completion of rehabilitation, since often a claimant will opt to receive OPM benefits concurrently with a schedule award, and concurrent receipt of OPM and OWCP benefits is prohibited during a period in which vocational rehabilitation services are being provided.

If a claimant is already receiving compensation for a schedule award while in rehabilitation, he or she should continue receiving those benefits unless the claimant is also receiving an annuity from OPM, in which case the claimant should be advised that he or she cannot be provided with vocational rehabilitation services while receiving an OPM annuity. The claimant should be offered an election, and if he or she elects OWCP benefits, the schedule award payments should be converted to payments for temporary total disability until completion of the rehabilitation effort. If the claimant elects OPM benefits, the schedule award benefits should continue and medical and factual development should be undertaken to determine the claimant's Loss of Wage-Earning Capacity (LWEC) at the end of the schedule award, but vocational rehabilitation efforts should be terminated. See paragraph 18 below for further direction when a claimant elects OPM benefits.

4. **Restoration Rights with the Federal Government**.

Section 8151 of the FECA provides civil service retention rights to Federal employees who have recovered either fully or partially from an employment-related injury or illness, and who can perform the duties of the original job or its equivalent. The EA must restore a permanent employee (i.e., one with career or career-conditional status) who recovers within one year after beginning compensation to that position or its equivalent. This provision does not apply to temporary or term employees. 20 C.F.R. §10.505 explains that the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position in accordance with 5 U.S.C. 8151 if the employee has fully recovered after one year. 20 C.F.R §353.301 provides an overview of restoration rights for fully recovered and partially recovered employees.

OPM has jurisdiction and is responsible for enforcing this section. See Pedro Beltran, 44 ECAB 222 (1992) and CharlesJ. McCuistion, 37 ECAB 193 (1985) (claims for job reinstatement are not within OWCP's jurisdiction).

a. OPM's regulations on retention rights are published at 5 C.F.R. §302, 330 and 353. They require agencies to grant leave without pay (LWOP) to disabled workers for at least the first year the injured worker is receiving compensation.

b. An injured worker who has been terminated and who wishes to reclaim his or her job should be advised to contact the EA. If this effort fails, OWCP will contact the EA, citing 5 U.S.C. 8151 as the basis for the worker's attempt to regain employment. In addition, 5 U.S.C. 8151 (b) (2) and its implementing regulations provide for priority placement under certain circumstances. If this course is also unsuccessful, the injured worker may be advised to exercise his or her appeal rights as provided by OPM.

c. When an injured worker resumes employment with the Federal government, the EA is required to verify that the worker had been receiving compensation during the entire period of absence from work, whether in LWOP status or separated. The agency will ask OWCP to advise whether the worker was receiving compensation and, if so, the period of compensation during which the worker was paid, so that the injured worker may be credited with all rights and benefits based on length of service.

d. Issues pertaining to retention rights should be referred to the EA or OPM, and CEs should not offer claimants advice on these rights. It should also be noted that not all individuals covered by FECA are entitled to restoration rights.

5. **Referrals for Vocational Rehabilitation Services.**

The probability of effective rehabilitation, resulting in the best return-to-work arrangement, is greatly increased when such efforts begin as early as possible in the recovery process. This paragraph addresses the criteria and procedures for referring cases for vocational rehabilitation services.

a. The Claims Examiner (CE) should monitor cases for adequacy of the medical reports in reporting work capacity and ensure that the reports are current. Where a return-to-work date has not been given, but the medical evidence shows that the claimant is not totally disabled and the medical condition has stabilized, the CE, or Field Nurse (FN) if one is assigned to the case, will obtain a completed Form OWCP-5 (or equivalent) to show the work limitations.

If the attending physician cannot furnish work limitations, or if they appear inconsistent with those expected, the CE should initiate a second opinion referral (see FECA PM 2-0810).

If the attending physician has not released the claimant to work, the CE may also seek opinion regarding whether an Occupational Rehabilitation Program (ORP) would be appropriate, as outlined in paragraph 12 of this chapter.

b. The CE should ensure that the file contains the claimant's position description, including a report of the physical requirements, and any special psychological requirements if applicable, for the job held at date of injury. This information may be requested from the EA when the case is accepted, when the first compensation payment is issued to the claimant, or at any other time.

c. Criteria for Referral. If the current medical evidence indicates that the claimant has objective residuals of the work-related condition and has stable, well-defined work limitations which allow him or her to work 8 hours per day, the case should be referred for vocational rehabilitation services. If varying descriptions of work limitations appear in file, it may be necessary to weigh the medical reports and identify the physician's report that represents the weight of medical evidence. (A limited referral may be made for placement services when the claimant can work at least 4 hours per day. See paragraph j(1) below.)

Note – Prior to referral, the CE should review the medical evidence carefully to be sure that the claimant's work related condition is still present and disabling. The work restrictions on file should be reviewed in conjunction with the requirements of the date of injury job to determine if the claimant is capable of performing that position, prior to a referral for vocational rehabilitation. If the claimant's work-related condition has resolved, or he or she is capable of performing the duties of the date of injury position, the case should not be referred for rehabilitation services. Instead, a notice of proposed termination of wage loss and/or medical benefits should be issued. See PM 2-1400.

(1) Work restrictions should be current at the time of the initial referral. The medical evidence can be from the attending physician, second opinion examiner, or referee physician. The evidence should clearly establish that the claimant has stable and well-defined residuals. While the restrictions do not have to be on Form OWCP-5, work limitations from the accepted employment conditions that prevent the claimant from returning to the job held at the time of injury should be set forth in sufficient detail in terms of limitations and capabilities for an assessment of rehabilitation/work readiness to be made.

(2) The claimant should be capable of at least sedentary work, as defined by the Dictionary of Occupational Titles, or OWCP-determined equivalent, (including, pushing, pulling, and lifting at least 10 pounds, one-third of the work day, etc). If placement with the previous employer is not possible, the claimant should be capable of working on a full-time basis. A limited referral for part-time placement with a new employer may be considered in those labor markets with sufficient part-time work in the commuting area. See paragraph j(1) below.

(3) When the referral is made, the CE may advise the claimant by letter what the CE considers the claimant's restrictions and capabilities to be and which physician's opinion represents the weight of medical evidence and why. If work restrictions were provided by a second opinion or referee physician, the CE should identify the weight of the medical evidence by completing a memo to file or addressing it clearly in the letter to the claimant. If the second opinion or referee narrative report and OWCP-5 appear to contradict each other (e.g., the narrative report indicates sedentary work, but the OWCP-5 indicates less than sedentary), the CE should clarify this inconsistency with the physician prior to assigning weight to that particular report and making the referral for vocational rehabilitation services.

(4) There should not be any outstanding medical issues, work-related or non-work-related, precluding participation in the rehabilitation effort. If there are non-work related conditions apparent in the file, any restrictions resulting from those conditions should be clarified prior to referral.

However, if the claimant's only other disabling condition is a non-work condition that post-dates the work injury, you may consider a limited referral for the purposes of establishing a constructed wage-earning capacity (WEC). See paragraph j(3) below.

d. The FN may recommend a vocational rehabilitation referral at the end of nurse services. A referral may also be desirable if the claimant has not collaborated with or fully benefited from nursing services.

e. Active FN cases may also be referred for dual tracking. The referral in these cases will be for Medical Rehabilitation and the period will usually be limited to 3 months for concurrent services. In these cases, the restrictions may not be completely defined. As a result, full plan development cannot begin immediately with these claimants, but, in the interest of expediting the return to work, the RC may assist with work hardening and functional capacity evaluation scheduling and begin the groundwork for the development of a return-to-work plan by obtaining the claimant's work history, performing preliminary labor market surveys, and conducting a transferable skills analysis.

The FN will focus on the medical aspects of the case, and the RC will focus on the vocational aspects of the case. Once the claimant has stable and well-defined restrictions, nurse intervention will cease and the RS will direct the RC to begin actual plan development. Refer to FECA PM 2-0600-8(c) and 2-0600-9(e) for further information on the dual tracking of cases.

f. The FN or CE may also recommend a task based rehabilitation referral in conjunction with FN services. For instance, if vocational testing, an ergonomic evaluation, or assistive technology would enable the employing agency to offer a job to the claimant or explore job opportunities for placement in another departmental position, the FN or CE may recommend a dual assignment for this purpose.

g. To identify cases for early intervention, the Rehabilitation Specialist (RS) may use reports which list unscreened cases on the periodic roll, or cases closed after nurse intervention. The RS will notify the CE of cases which appear appropriate for rehabilitation services, including Occupational Rehabilitation Programs (ORPs). Unless there is a medical reason that the case is not in posture for referral, the CE should refer the case for rehabilitation services.

h. Cases in which rehabilitation services were previously terminated for reasons which are either unclear or no longer pertinent may be referred as long as the claimant is able to work 8 hours.

i. Making the Referral. The CE refers cases for vocational rehabilitation services using Form OWCP-14 (or equivalent). The referral should include:

(1) The accepted conditions in the case, as well any accepted conditions in other FECA files that are pertinent with regard to medical restrictions. Other significant non-work related conditions should also be noted.

(2) The name of the attending physician.

(3) The physician's name and date of medical report which represents the weight of medical evidence.

(4) The date on which disability (or recurrent disability) began, to identify the one-year time frame for placement with the previous employer.

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

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

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

(8) When the case is being referred on a limited basis, the CE should include the nature of the limited referral, the CE's assessment of the situation, and the desired action from the RC. See paragraph j below.

(9) An indication if Field Nurse (FN) services are active and the reasons for continued FN service (e.g., a remaining medical issue is still being resolved).

(10) An indication as to whether or not the agency has specifically indicated that placement services with the previous employer are inappropriate.

Once the referral has been completed and made a part of the case record, the CE should send a Vocational Rehabilitation referral to the RS via iFECS, which will automatically populate the appropriate code in the iFECS Disability Management (DM) record. See PM Chapter 2-601 for more details on DM Coding.

j. Limited Referrals. If the claimant is only able to perform part-time or sub-sedentary work, or could otherwise engage in active vocational rehabilitation services but for a non-employment-related condition which post-dates the injury, a limited referral for vocational rehabilitation services may be appropriate.

(1) For claimants who cannot work 8 hours per day, a referral may be made for placement services with the previous employer. Placement with a new employer may be considered in those labor markets with sufficient part-time work in the commuting area. If later medical evidence demonstrates an improvement in medical status, attempts to establish the claimant's ability to work a full day should be pursued.

(2) An Occupational Rehabilitation Program (ORP) may be appropriate when the specific work limitations are unknown or sub-sedentary but there is an expectation that a short period of medical rehabilitation will result in restrictions which can be used for a return to work. The CE may refer the claimant for an ORP when the physician prescribes a functional capacity evaluation, work hardening, or any other therapy program aimed at exploring work capabilities and documenting work restrictions. See paragraph 12 of this chapter for more information on ORPs.

(3) Where the weight of the medical evidence establishes that the claimant could work in at least a sedentary capacity due to the work injury, but is more severely restricted from work due to a non-employment-related condition which post-dates the injury, the CE should document the file with medical evidence that establishes the claimant's work tolerance limitations based on the accepted work-related conditions and any pre-existing conditions. Whether a condition is considered a pre-existing condition should be determined by the date of first medical treatment for the non-employment-related condition as documented in the file.

The CE should identify the non-employment-related condition(s) which arose after the work injury and indicate that any resulting restrictions need not be taken into consideration when identifying positions which represent the claimant's wage-earning capacity. A referral will be made solely for the purpose of determining the claimant's capacity to earn wages in the open labor market based on the restrictions attributable to the work injury and any pre-existing medical conditions.

6. **Placement with Previous Employer (PPE).**

Once a case has been opened in vocational rehabilitation for return-to-work efforts, the RC will work with the EA to modify the claimant's DOI job or identify another position within the agency (or department) which the claimant can perform, unless the agency has already indicated that reemployment with the agency is not possible.

a. Roles and responsibilities. In order for placement with the previous employer to be successful, active participation of the claimant, RC, and OWCP staff, as well as the EA, is crucial.

(1) Role of the RS. Within 5 business days of receiving the referral, the RS should take the following actions:

(a) Refer the claimant to an RC to address PPE, ensuring that the RC understands the need to reach a decision concerning employability within one year after wage loss began (or recurred) due to the claimant's retention rights, as described in paragraph 4 of this chapter;

(b) Contact the previous employer to discuss prospects for re-employment, including the use of assistive technology to facilitate work; and

(c) Advise the CE that the case has been opened via Form OWCP-35 or other file documentation.

Once the case has been referred, the RS should advise the CE if the claimant refuses to cooperate with vocational rehabilitation services. The CE will then need to review the case for possible sanctions as described in paragraph 17 of this chapter.

(2) Role of the RC. Working under the guidance of the RS, the RC provides counseling and guidance to the claimant to make sure that he or she understands the process and associated responsibilities. The RC maintains regular contact with the claimant and the previous employer to elicit job offers compatible with the work limitations identified by the CE. The RC may give the employer assistance in preparing a job description and identifying equipment which may be needed in order for the claimant to perform the specific duties of an offered position. As necessary, the RC may also arrange for job site analysis, vocational testing, and/or vocational evaluation to help the previous employer identify placement possibilities.

The RC may be asked to contact the district office after the first visit

with the claimant so that all pertinent parties can discuss the rehabilitation effort. The RC may also participate in scheduled conferences.

(3) Role of the CE. The CE responds to any requests for medical documentation and determines suitability of any job offer that is made. If the claimant fails to cooperate or refuses a suitable job offer, the CE promptly issues a warning letter (see paragraph 17 of this chapter) and follows up to ensure compliance or issues a final decision with regard to the job offer.

(4) Role of the claimant. Claimants must be flexible and realistic regarding adjustments needed in the return-to-work effort, such as changes in shifts, salary, new work environment, etc. They are required to cooperate with efforts to find a suitable position with their EA and provide medical documentation when needed.

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

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

(2) If no job offer is developed by the 85th day, or it seems apparent that there is no real interest in formulating a job offer, the RC will make a final contact with the previous employer to assess its interest in extending a job offer. If a job offer is not forthcoming, or there is no interest in developing such an offer, the RC will so notify the RS by telephone.

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

d. Outcomes.

(1) If the claimant returns to work with the previous employer, the RC will follow the claimant for at least 60 days after placement and submit a final report. The RS will advise the CE by OWCP-3 (or equivalent) of the outcome of PPE effort. The CE should then review the case to determine whether a formal LWEC decision is appropriate, even if the LWEC is 0%. If the job does not reflect the claimant's maximum wage-earning capacity in terms of duties performed and hours worked, the CE should continue to monitor the case.

(2) If the EA provides an offer of suitable employment, but the claimant does not return to work, the CE should review the case for application of sanctions in accordance with 8106(c). See PM 2-814.

(3) If the EA does not provide an offer of suitable employment, the CE and RS will need to take the next appropriate action in the vocational rehabilitation process. In these types of cases, the RC will usually be asked to develop an alternative plan, based on vocational testing, which may include medical rehabilitation, training, and/or placement services for a new employer.

If the claimant cannot work 8 hours per day, the RS may interrupt services until a full-time schedule is feasible. The CE may also need to obtain additional medical opinion or a recommendation for an occupational rehabilitation plan from the attending physician, or take some other action to increase the claimant's level of readiness to seek work with a new employer. At this stage of the re-employment effort, it is not appropriate to refer the case back to an FN for additional action. The RS and RC should supervise any occupational rehabilitation program or similar effort.

7. **Plan Development.**

If efforts to return the claimant to work with the EA are not successful, then the RC will need to develop a plan for the claimant's return to work with a new employer. During this phase of rehabilitation, the RC will identify jobs that are medically and vocationally suitable and reasonably available in the claimant's commuting area.

In some cases, plan development will be the initial phase of vocational rehabilitation, and in others it will follow services that were aimed at placement with the previous employer. If plan development is the initial phase, then the RC will need to conduct the initial interview. This interview will help the RC establish a rapport with the claimant, allow the RC to provide information about the rehabilitation process, and provide an opportunity for the RC to gather background information from the claimant that is necessary for a reemployment plan, such as employment history and educational background. If services were already provided for placement with the previous employer, the initial interview will already have been conducted.

Regardless of when plan development occurs in the vocational rehabilitation process, the services provided and the method of providing them are the same. The evidence and documentation submitted to support the plan, and the responsibilities of all parties involved, remain constant.

a. Selecting Jobs for the Reemployment Plan. Suitable jobs are identified by the RC while developing the reemployment plan. A number of factors are considered, including medical and vocational suitability and whether the jobs are reasonably available in the claimant's commuting area.

(1) Medically Suitable. All jobs targeted in the reemployment plan have to be medically suitable. The established restrictions are compared to the physical requirements of each position as listed in the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles or other guidance such as the DFEC Physical Demand and/or Environmental Condition Definitions. See Exhibit 1 (Physical Demand Definitions) and Exhibit 2 (Environmental Conditions Definitions). The job requirements must not exceed the claimant's work abilities. See paragraph 5 of this chapter (Referrals for Vocational Rehabilitation Services) for more details about the medical documentation needed for a reemployment plan.

(2) Vocationally Suitable. The RC's documentation also should support that the targeted positions are vocationally suitable. If job placement will occur immediately after plan approval, then the claimant must be capable of performing the identified jobs at the time of plan development. Vocational suitability can be established through a transferable skills analysis and vocational testing. If the proposed reemployment plan calls for training, then the evidence should establish that the claimant will have the vocational skills for the targeted jobs following training. In both cases, the claimant's skills and training are compared to the specific vocational preparation requirements as described in the Dictionary of Occupational Titles, or OWCP-determined equivalent.

(3) Reasonable Availability. Reasonable availability needs to be established for each position targeted in the plan. The RC uses professional experience and knowledge of the job market to document that the jobs which are medically and vocationally suitable for the claimant are also available in

sufficient numbers to make successful placement reasonable. The RC will conduct a survey of the local labor market and document availability of targeted jobs by citing sources such as the local State employment service, the local Chamber of Commerce, employer contacts, and actual job postings. This research will also be used to establish salary information for the targeted jobs. The concept of "reasonable availability" does not necessarily equate to actual current job openings, which are dependent on the current economic climate. If the position is performed in sufficient numbers within the commuting area, it is considered to be "reasonably available."

b. Elements of a Vocational Reemployment Plan. There are a number of elements that the RC needs to ensure are included when plan approval is requested.

(1) Injured worker factors which affect the plan need to be documented. The claimant's medical status and resulting restrictions should be reviewed in this section. Additionally, any social factors which may affect plan success, such as family support, should be mentioned. Lastly, the results of any vocational testing should be discussed.

(2) Plan goals. At least two different medically and vocationally suitable jobs should be identified. A completed Form OWCP-66 is provided for each position that lists the job description according to the Dictionary of Occupational Titles, or OWCP-determined equivalent, and the physical requirements per the Selected Characteristics or other guidance such as the DFEC Physical Demand and/or Environmental Condition Definitions. See Exhibit 1 (Physical Demand Definitions) and Exhibit 2 (Environmental Conditions Definitions). Current starting salary information should also be provided on this form and the source should be documented.

(3) Documentation of job availability in the form of a labor market survey should be included with the plan. In addition to the sources mentioned above, the RC may include additional information such as an industrial survey or a specific number of actual employer contacts.

(4) Plan justification and recommendation. The plan should describe the specific actions which are to be taken by the injured worker, the RC, and other professionals or facilities to reach the stated goals, along with an estimate of the time and the costs required. If training is recommended, the difference between the injured worker's earning capacity with and without training should be discussed.

There should also be a document which establishes that the claimant agrees with the plan as evidenced by his or her signature. This can be accomplished via a document created by the RC (such as an Individual Placement Plan) or via Form OWCP-16 if the plan will require additional funds beyond the amount initially approved by the RS. The plan should list the specific actions to be taken by the claimant and the RC that are necessary to reach the plan goals and provide time frames and estimated costs associated with these goals.

c. Roles and responsibilities. The successful development of a plan for reemployment requires the active participation of the claimant, RC, and OWCP staff.

(1) Role of the RS. The RS actively supervises the development of the plan and ensures the submission of monthly reports, as well as adherence to time frames. The RS issues guidance to the RC if the rehabilitation effort is not proceeding appropriately. Once the plan has been submitted, the RS reviews and approves it or returns it if the identified jobs are not suitable or the plan lacks the necessary documentation. Any extension requests should be reviewed by the RS.

(2) Role of the RC. The RC should be responsive to the RS's guidance, submit a complete and well-supported plan in the time allotted, and refrain from initiating the planned services without the approval of the RS. The RC should immediately report any non-cooperation to OWCP. The RC will maintain regular contact with the claimant, schedule any needed testing, and counsel the claimant. The RC has up to 90 days to submit a vocational rehabilitation plan and should request an extension before this period expires if there are extenuating circumstances.

(3) Role of the CE. The CE responds to any requests for medical documentation. If the claimant fails to cooperate with plan development, the CE promptly issues a warning letter (see paragraph 17 of this chapter) and follows up to ensure compliance or issues a final decision for continued non-cooperation. When the RS approves the plan, the CE has 5 business days to review the plan and make a determination on the medical suitability of all targeted positions. Once the plan has been approved by all parties, the CE should send a plan approval letter to the claimant.

(4) Role of the claimant. The claimant is expected to cooperate with efforts to develop a reemployment plan. This includes responding to phone calls from the RC, appearing for scheduled meetings, providing needed background information, undergoing vocational testing, and being willing to explore new occupations outside of the Federal government. In addition, the claimant cannot refuse to sign a suitable vocational rehabilitation plan without justification. For training plans, it is mandatory that the claimant sign Form OWCP-16 to indicate full understanding and agreement. Failure to sign the form is considered non-cooperation on the claimant's part and may require initiation of sanctions. (Refer to paragraph 17 of this chapter.)

d. Time Frames. The RC has up to 90 days to submit a vocational rehabilitation plan. If there are extenuating circumstances, an extension should be requested before that period expires. After the RS approves the plan, the CE should review the plan and make a determination on the medical suitability of all targeted positions within 5 business days.

e. Once the plan is approved, the CE should send a plan approval letter

to the claimant, and the RS will direct the RC to move on to the next phase of vocational rehabilitation. If training was a part of the approved plan, that will be the next phase. Otherwise, the RC and claimant will move directly to job placement.

8. **Training.**

A training program should be considered before placement with a new employer, if there is reason to believe that placement will not be accomplished without training. A training plan may also be considered if the claimant is a good candidate and training will significantly reduce the difference between the current salary of the job held on the date of injury and the salary in new employment with training, as compared to employment following direct placement without training.

After determining the claimant's job skills by completing a transferable skills analysis and vocational testing, the RC will review the claimant's medical restrictions and research the local job market in order to determine the claimant's employment prospects. If placement cannot reasonably be accomplished based on the claimant's current experience and aptitudes, then training may be considered.

Any proposed training program must fit the injured worker's abilities and limitations and must prepare the claimant for jobs that are available in the local labor market. The cost of the proposed training plan should be easily justifiable in view of the resulting increase in the claimant's wage-earning capacity. The claimant's motivation level and likelihood of success in the proposed training should also be considered. The claimant's personal desire to pursue a particular type of training is not the primary factor to consider when assessing training options.

If training is needed, short-term or pre-vocational training that would serve to upgrade basic skills are the preferred options. Long-term training plans should be pursued as a last resort, since returning the claimant to work in the shortest time possible is a primary focus of vocational rehabilitation.

a. Types of training. The type of training provided will depend on the above mentioned factors.

(1) Pre-vocational training is short-term and serves to upgrade basic skills such as literacy, but is not necessarily aimed at a specific occupation. For example, a GED preparation course and test would be considered pre-vocational training; or a several-week course that upgrades basic computer skills needed for many office jobs. Pre-vocational training can either prepare claimants for jobs existing in the labor market or can prepare them for more in-depth training.

(2) Formal training courses, or refresher courses, can be provided through business or trade schools, colleges, apprenticeship programs, tutoring, etc. Formal training can be provided for professional, semi-professional, technical, clerical, agricultural, skilled or semi-skilled occupations.

(a) Short-term training should be considered first because it is likely to be more cost-effective and requires less of a commitment from the claimant. A certification program requiring several months of training is preferable to a multi-year degree program. If the claimant has skills or a degree in a particular field such as the health field but has not maintained the required certifications or licensure, a refresher course may be considered.

(b) Longer-term training, such as college training, should only be considered if the claimant shows exceptional ability and there is a great probability of employment with minimal or no loss of wage-earning capacity upon completion of the program.

(3) On-the-job training is another option for increasing the employability of the claimant. The program should have a well-defined period and be expected to lead to employment. There should be a written agreement with the employer which identifies the skills that the claimant will gain from this training. Any salary paid to the claimant during this training should also be listed on the agreement.

Assisted Reemployment, as outlined in paragraph 10 of this chapter, should also be considered in conjunction with a training plan.

b. Roles and responsibilities. The successful completion of a training program requires the active participation of the claimant, RC and OWCP staff.

(1) Role of the RS. The RS is responsible for ensuring that an appropriate facility is selected for the approved training and that the necessary approval documentation is issued. The RS will monitor RC reports and training documentation. If the RC communicates any instances of non-cooperation by the claimant, the RS will report this to the CE promptly so that appropriate action can be taken.

(2) Role of the RC. The RC assists the claimant with registration and obtaining the needed supplies for approved training. The RC provides guidance and counseling during training and maintains contact with the claimant at regular intervals. If needed, the RC can interact with the training institution and other parties to resolve any issues which arise. The RC also obtains transcripts, certificates, or other documentation of successful training progress and completion.

(3) Role of the CE. The CE reviews RC's reports and monitors the claimant's progress in training. If non-cooperation occurs, the CE issues the appropriate warning letters and sanction decisions. See paragraph 17 of this chapter for more information on non-cooperation. Any medical issues which arise during training should be addressed and resolved by the CE.

(4) Role of the claimant. The claimant should have been made aware of what is expected during training because his/her responsibilities are laid out when the plan is developed. The claimant is required to be responsive to RC communication and to show up for any scheduled meetings. During training, the claimant is also expected to maintain a "C" average in all classes and provide documentation of grades, certificates, etc. Regular attendance is required at all approved training programs.

c. Time Frames. The length of the training phase will vary depending on the type of training pursued.

d. At the completion of the approved training plan, the claimant will be provided with 90 days of placement services.

9. **Placement with New Employer (PNE).**

Placement New Employer is the phase of vocational rehabilitation during which an injured worker is provided services aimed at obtaining work with a different employer, other than the original EA, usually in the private sector (though another federal employer may also be an option). PNE services may be offered when no training has been conducted or after an approved training plan has ended. It is the phase of vocational rehabilitation where the actual job search is implemented in accordance with the approved vocational rehabilitation plan that was created in Plan Development.

a. Services offered during this phase include, but are not limited to:

(1) Assistance with developing a resume.

(2) Counseling on proper interview appearance and behavior.

(3) Provision of job leads.

(4) Assisted reemployment funds, when appropriate. See paragraph 10 of this chapter for more information on Assisted Reemployment.

b. Roles and Responsibilities. Like all other phases of vocational rehabilitation, in order for placement with a new employer to be successful, active participation by the claimant, RC, and OWCP staff is crucial.

(1) Role of the RS. The RS oversees the implementation of the approved placement plan, ensuring that all aspects are in accordance with OWCP standards and procedures. This includes the following:

(a) Managing the RC by evaluating progress and requesting changes in the plan, as necessary.

(b) Reviewing reports and bills submitted for reimbursement.

(c) Acting as a mediator, should differences arise between the RC and the injured worker.

(d) Communicating any instances of non-cooperation or other factors that may impede the return-to-work effort to the CE.

(2) Role of the RC. The RC is responsible for providing job search services to the claimant, which may include the following:

(a) Providing job leads to the claimant and contacting potential employers on behalf of the claimant.

(b) Actively assessing the claimant's job search and identifying obstacles and problems the injured worker is having with his or her search; providing constructive counseling and guidance to assist the claimant in overcoming these obstacles.

(c) Counseling the claimant about interview appearance and behavior; conducting mock interviews or videotaped practice interviews to help the claimant develop interviewing skills.

(d) Assisting with resume writing and tailoring it to particular jobs.

(e) Ensuring the claimant is complying with the placement efforts by following up on job leads provided and appropriately participating in scheduled interviews.

(f) Promptly reporting any non-cooperation to the RS while continuing to provide placement services for the allotted 90 days. The RC should counsel the claimant on the importance of reemployment and the possible consequences of failure to do so. The RC should make sure that the claimant understands his or her responsibilities in the placement phase.

(g) Recommending assisted reemployment benefits, when appropriate.

(3) Role of the CE. The CE participates in this phase in the following ways:

(a) At the beginning of placement new employer, the CE should advise the claimant that OWCP will provide 90 days of placement assistance and that his or her LWEC probably will be based on the job for which placement is being attempted. The 90 days is calculated from the date of the OWCP-3 (or equivalent) approving placement with a new employer.

(b) The CE should monitor the claimant's return-to-work progress and promptly respond to requests for intervention from the RC and RS throughout the 90 days of placement services.

(c) If new medical evidence is provided by the claimant, the CE needs to evaluate it promptly and notify the RS if there is a change in the weight of the medical evidence that affects the vocational rehabilitation efforts currently in progress.

(d) Arranging for a conference with appropriate parties if it is determined that one would be helpful.

(4) Role of the Claimant. The claimant is required to cooperate fully with the RC and adhere to the approved rehabilitation plan by:

(a) Being responsive to the RC. This includes returning phone calls, appearing for scheduled meetings, and responding to requests for information.

(b) Performing all job search activities presented by the RC. This can include contacting the job leads provided, keeping a log of job search activities, attending job fairs, scheduling and attending interviews, and other related activities.

c. Time Frames. The PNE phase usually lasts for 90 days. This period may be extended, if agreed upon by the CE and RS, if the claimant is motivated and granting such an extension is likely to lead to job placement.

d. Upon completion of placement services, one of two things will occur. If the claimant has obtained a job through placement, the vocational rehabilitation effort will move to Employed status and the RC will follow the claimant's progress for 60 days to ensure a successful return to work. If the claimant fails to obtain employment, the CE will issue a pre-reduction notice for a constructed loss of wage-earning capacity.

10. **Assisted Reemployment.**

Assisted reemployment is a subsidy, used during PNE, designed to encourage employers to choose qualified rehabilitated workers whom they might otherwise not hire.

Disabled Federal workers with skills transferable to jobs within the general labor market may prove difficult to place due to economic factors in both the Federal and private employment sectors. Assisted reemployment is designed to increase the number of permanently disabled employees who successfully return to the labor force by providing wage reimbursement to potential employers.

a. General Provisions.

(1) Assisted reemployment will allow for up to three years of partial reimbursement of salaries to employers, other than the original employer, who reemploy disabled FECA claimants. The program allows reimbursement, on a quarterly basis, to the new employer of salary paid to the claimant up to 75% the first year, up to 50% the second year, and up to 25% the third and final year.

(2) These wage subsidies to the employer plus the LWEC payment to the claimant shall never exceed the amount of compensation which would be paid to the claimant if there were an absence of employment. Similarly, if basic compensation is being paid, i.e., the claimant has no dependents, the subsidy rate may not exceed 66 2/3 percent.

(3) Should compensation be terminated (e.g., because work-related disability ceases), wage subsidies to the employer should also be discontinued.

(4) The RS and RC will consider jobs which correspond to the claimant's educational background and employment history.

(5) The CE will ensure that the employment under consideration conforms to the medical limitations imposed by the residuals of the work injury and any concurrent conditions.

b. Cooperative Agreement. Once an employer has agreed to hire the claimant under this program, a cooperative agreement between OWCP and the new employer must be drawn up and signed by the RS. The title of the job, the job duties, the salary to be paid, and the wage subsidy rate will all be specified in a cooperative agreement.

c. Approval.

(1) Concurrence of CE. The CE should review the job offer to be sure it meets the following elements:

(a) The offer must be in writing;

(b) It must conform to the claimant's work limitations and be suitable within the meaning of Section 8106(c) of the FECA; and

(c) It must support an LWEC rating, i.e., the earnings must fairly and reasonably represent the claimant's wage-earning capacity.

The CE must concur with the cooperative agreement, and this concurrence should be documented in the case file. If the CE agrees with the Assisted Reemployment subsidy, the cooperative agreement should be forwarded to the District Director for review.

(2) Approval of the District Director. The cooperative agreement and CE's concurrence will be reviewed by the District Director. If the District Director approves the subsidy, the approval should be reflected in the file. Assisted reemployment cannot commence until the agreement is approved by the District Director.

d. Payment of Compensation.

(1) To eliminate the possibility of an overpayment, the CE should remove the case from the periodic roll as soon as the beginning date of work is known.

(2) Any additional entitlement to compensation on the basis of temporary total disability should be paid on the daily roll until the employment commences.

(3) If the claimant is entitled to compensation on the basis of a LWEC after returning to employment, the CE should set up payment using the Shadrick formula. After the claimant has successfully worked for 60 days, the CE should review the case to issue a formal LWEC decision (including formal findings of no LWEC).

11. **Employed.**

If a claimant finds employment with either the previous employer or a new employer, the vocational rehabilitation effort moves to Employed status in order to ensure that the claimant successfully works the position for 60 days. This phase allows OWCP to provide follow-up services, in recognition that this initial period is a period of readjustment and often determines the success or failure of the rehabilitation effort.

The RC should contact the claimant at the end of the first day, first month, and second month on the job to check on the adjustment to the workplace and the position. The RC should remain available to the claimant to assist with the readjustment by providing counseling and support.

During the Employed phase, the RC will obtain all documentation pertaining to the new position, such as the name and address of the employer, the job title, the Dictionary of Occupational Titles code (if applicable), the starting date, hours per week, etc. If the claimant does not want the RC to follow up with the new employer regarding job information and/or the claimant's return to work, all information must be obtained from the claimant.

The RC should notify the RS immediately when any situation arises that jeopardizes the claimant's successful return to work. The RC should provide counseling and work with the claimant and the employer (if authorized by the claimant) to solve the problems. The RC can provide services such as job site analysis, ergonomic assessment, and the provision of adaptive equipment during this phase. If the claimant and employer arrive at an impasse, the RC may recommend a conference call with OWCP staff to resolve any issues surrounding the new position.

12. **Medical Rehabilitation.**

Medical Rehabilitation refers to those medical and related services necessary to correct, minimize or modify the impairment caused by a disease or injury so that the injured worker can return to an adequate level of function and employment. Thus, it is distinguished from actual medical treatment to cure or relieve the effects of the injury.

a. Various medical services can be provided during this phase:

(1) Intensive services provided in catastrophic claims. This can be done in coordination with the FN and can include setting up home health care, arranging for medical transport, etc.

(2) Functional Capacity Evaluations (FCE), work hardening, or any other physical therapy program aimed at producing work tolerance limitations. These are also referred to as Occupational Rehabilitation Programs (ORP). These programs should only be provided as part of vocational rehabilitation services if there is an expectation that they will lead to restrictions which can then be used for a return-to-work effort. FCEs can be offered outside of vocational rehabilitation under FN direction or CE case management. See part b in this section for more information on ORPs.

(3) Speech therapy, orthotics, prosthetics, or other assistive devices that would make the claimant employable.

(4) Psychiatric counseling, drug addiction counseling, pain management clinics. OWCP may approve treatment for addiction to drugs (legal or illegal) that is not specifically work-related, if the addiction is impeding the claimant's return to work. See paragraph 16 of this chapter for more information on substance abuse during vocational rehabilitation.

Aside from drug addiction treatment, OWCP is not responsible for medical costs associated with conditions unrelated to the work injury. Nevertheless, the RC may still encourage the claimant to seek treatment.

(5) Housing and vehicle modifications can be provided under the vocational rehabilitation program. See FECA PM 2-1800, Housing and Vehicle Modifications, for further details.

b. Occupational Rehabilitation Programs**.** Services which help the injured worker return to work through the use of abbreviated workdays or altered job duties are known as Occupational Rehabilitation Programs (ORPs).

(1) Kinds of ORPs. There are two kinds of ORPs.

(a) Return-to-work (RTW) ORPs are intended for claimants who were injured more than 60 days ago, have not worked for at least 30 days, and are returning to a particular job and employer with defined duties, including transitional duties. RTW ORPs are highly structured, job oriented, goal-directed, individualized, and interdisciplinary. They are intended to maximize the claimant's ability to return to work. Real or simulated work activities are used in conjunction with graded conditioning tasks to aid the transition between acute care and return to work.

(b) Work Readiness (WR) ORPs are used when no specific job is available with a known employer. Services provided have the potential to improve the claimant's work options. They are designed to evaluate and treat the claimant's physical, behavioral, and vocational functions. These programs include real or simulated job-specific work tasks with modifications. The WR ORP uses many of the tests, evaluations, and restorative services used in the RTW ORP, but the job skill requirements under this category are less well defined. The goal in most cases is to maximize potential job options rather than prepare for a specific job. Sometimes, however, the goal is to document the claimant's job potential, and/or measure ability to improve physical tolerance, productivity, and work behavior.

(2) Referral for ORPs. CEs should refer cases meeting the criteria stated in paragraph 5 of this chapter to the RS for an ORP assessment. The RS may also initiate an ORP placement. Also, the RS will notify the responsible CE in any case already open for vocational rehabilitation which, in his or her opinion, may benefit from this type of service.

(3) Initial RS Actions. The RS opens for rehabilitation those cases referred by the CE that meet the basic criteria. The RS refers the case to a RC for a screening interview and the scheduling of a FCE to determine the type and nature of the ORP most suited to the claimant's needs.

(4) Authorization of ORP. When the FCE is completed, the RS authorizes the kind of ORP most suitable for the claimant. Once the claimant is enrolled in the ORP, the RS notifies the treating physician, employer (when available), the RC, and the CE that the program has been authorized.

(5) Obstacles to Completion. Medical or other issues which could delay or terminate the ORP, such as the emergence of non-work related conditions, recurrences, complaints of high levels of pain, etc. must be reported immediately to the RS and CE. When the ORP is interrupted, the RC notifies the RS immediately, carefully detailing the reason(s) for the interruption. The RS communicates this fact to the CE and recommends an appropriate course of action based on the circumstances of the case.

(6) Outcomes. The following outcomes are based on the results of a completed ORP:

(a) Where the claimant cannot perform the duties of the previous employment or the targeted jobs, the RS may place the case in Plan Development, with the concurrence of the CE, to consider other rehabilitation solutions.

(b) Where the claimant can perform the duties of the date of injury job, the RS should notify the CE immediately.

(7) Reports. The ORP facility must submit at least two reports. The FCE report is the basis for the ORP program plan. The final report should contain the following:

(a) The present and potential status of the claimant for each of the elements reported in the FCE or the ORP plan, including the positive or negative changes that have occurred during the program, as well as information on the claimant's attendance, efforts, attitude, and general condition.

(b) Specific information on the vocational and functional status of the claimant and relationship to the targeted job(s) and fitness for return to work.

(c) Any issues related to work site safety, accommodations, ergonomics, transportation, etc.

(d) Any additional relevant information, such as recommendations for maintenance of work capacity, improvement in functional status, considerations for alternative occupations, and need for continued monitoring and support.

c. Medical rehabilitation services can be offered at any time in the life of a claim if they are deemed appropriate. The rehabilitation effort may begin with this phase if an FCE is scheduled and there is an expectation of work restrictions at the end. On the other hand, if a claimant requires drug addiction counseling after the rehabilitation effort has already begun, this phase could follow placement efforts with the previous employer or even plan development.

d. Ideally, medical rehabilitation leads to the identification of work restrictions that can be utilized for a return-to-work effort. However, depending on the reason for referral, there can be several outcomes from medical rehabilitation.

(1) If medical rehabilitation is utilized for coordination of care in catastrophic injuries or for coordinating housing or vehicle modifications, then the rehabilitation efforts will be closed once these services have been provided.

(2) If the medical rehabilitation services result in work restrictions which can be used for a return-to-work effort, then the case will either move to Placement or Plan Development.

(3) If the period of medical rehabilitation occurred during an approved plan and the resulting work restrictions do not rule out the jobs previously targeted, then the rehabilitation effort can resume in whatever stage is appropriate. If new restrictions result, a new rehabilitation plan may be needed.

(4) If medical rehabilitation fails to result in work restrictions that can be used for a return-to-work effort, the rehabilitation file should be closed or, if deemed appropriate by the RS and CE, placed in Interrupt status.

13. **Interrupt.**

During vocational rehabilitation intervention, issues may arise which can be resolved in a relatively short period of time. Instead of closing the vocational rehabilitation file, there are options which allow the RC to remain active in the claim while other interventions are undertaken.

Interrupt status is used when rehabilitation action is suspended temporarily but is expected to resume in a short time, e.g. a delay until a training course begins, recovery from surgery, etc.

In order for the RS to consider this status, there must be a significant probability of eventual rehabilitation, the postponement should generally be expected to last six months or less, and any changes in the claimant's medical condition must be reviewed with the CE.

a. When a case is placed in Interrupt status, the RC will maintain regular but limited contact with the claimant. Substantial services will not be offered because of limitations on the allowable hours for the RC to work on the case. If services are appropriate, another phase must be considered.

b. If the reason for the interruption is medical in nature, a determination must be made by the CE and the RS whether medical rehabilitation is appropriate. (See paragraph 12 in this chapter.)

In instances where medical rehabilitation is not appropriate, such as the need for the CE to schedule a referee examination to resolve a medical conflict, then the Interrupt status will end as soon as the medical issue is resolved. The case will either move into a rehabilitation phase which offers services or be closed, depending on the outcome of the medical management of the claim.

c. A case may be placed in Interrupt status if a training plan is approved but there is a delay before school begins. As soon as the approved training program begins, the case will move from Interrupt status to the Training phase.

d. Interrupt status should not last for more than six months. At that time, the CE and the RS should review the case and determine whether further services are warranted or rehabilitation closure is appropriate.

14. **Communication Among the CE, RS, RC, and Claimant.**

For rehabilitation efforts to be successful, the CE, RS, RC, and claimant must have frequent and clear communication.

a. Cooperative Effort. Communication pertaining to any issues relevant to rehabilitation should flow between all parties as needed. Rehabilitation is a team effort that includes the claimant, CE, RS, and RC. It is essential for all members of this team to remain informed of the progress of the case throughout the course of rehabilitation.

The CE should receive periodic reports from the RS on Form OWCP-3 (or equivalent) whenever the status of rehabilitation changes or a significant event occurs. While a vocational rehabilitation program may last for several months or more than a year, counselors are required to report monthly or bimonthly, depending on the phase of vocational rehabilitation efforts. It is imperative that the CE stay informed of the progress by reading the RC reports. Since late RC reporting requires RS action, the CE should request a status report from the RS at any point the CE is aware that the RC reporting is delinquent, or there is a question about the current status. Often this can be done in person, or by sending a short memo to the RS. The CE and RS should be in active communication if it is unclear why the rehabilitation process has exceeded the time frames set forth in the previous paragraphs of this chapter.

The CE and RC are encouraged to discuss issues as needed, but they must remember to include the RS in, or inform the RS of, the discussion. An important limitation to keep in mind is that it is the responsibility of the RS, not the CE, to direct RCs to change vocational rehabilitation statuses, and to approve or terminate services.

b. Change in Medical Status during Vocational Rehabilitation. The work tolerance limitations identified by the CE to the RS may change during the vocational rehabilitation effort; if this happens, the CE should advise the RS of the change as soon as possible. The RC may contact the claimant's physician and discuss the work limitations, if authorized by the CE directly or through the RS. If the physician recommends a change in work limitations, whether stricter or lighter, the RC should submit these work limitations to the CE through the RS. It is the CE, and not the RS or RC, who determines the accepted work limitations. It is important that the CE evaluate any new medical evidence and advise all parties of the current weight of medical evidence in the case or the need for additional medical development. See paragraph 15 of this chapter for more information on managing medical issues during vocational rehabilitation.

c. Non-cooperation. The RC should notify the CE and RS of any instances of non-cooperation so that the CE may act promptly. See paragraph 17 of this chapter for more information on the procedures for responding to instances of non-cooperation.

d. Conferences. A conference is an especially useful tool to bring multiple parties together to resolve issues, and is an excellent tool to discuss, coordinate and move cases forward in the rehabilitation process. This can occur when issues arise unexpectedly that could possibly delay or derail the process, or at set points during the rehabilitation process when a conference can help facilitate understanding,

resolve misunderstandings, or provide information where a dialogue would be more productive.

Since it is critical to keep all parties informed, and to ensure that all parties hear the same information at the same time, any rehabilitation-related conference should usually include the RS and/or the RC. (The only exception to this is if the CE chooses to conduct a conference just prior to the rehabilitation referral to help the claimant understand what to expect in a general way once the referral is made). Even if the RS or the RC is not present at the conference, the absent party should receive a copy of the subsequent conference documentation. See FECA PM 2-0500 for a discussion of formal conferences and 2-0600-12 for a discussion of informal conferences.

Situations that can benefit from a rehabilitation-related conference, though not limited to these topics, are:

(1) Initial referral: to explain the process to the claimant in a general way.

(2) Job Offer: if a job offer is pending and the claimant has not signed the offer or returned to work, or the claimant indicates concerns with the offered position.

(3) Training plan: if concerns have arisen regarding the viability of the plan or the willingness of the claimant to fully participate; or if the plan being considered is greater than $20,000. While rare, it is important to conduct a conference when considering such a costly plan to help determine whether the claimant has intentions of fully participating with the end goal of obtaining employment.

(4) Medical concerns: any time medical issues arise that have the potential to delay or derail full participation. The earlier these issues are addressed, the more effective rehabilitation can be.

(5) Non-cooperation: to explain to the claimant the responsibilities and consequences for non-cooperation. This occurs in conjunction with a warning letter, if warranted.

(6) Placement: at or near the time when placement services start, in order to explain to the claimant the process and the services available through placement. The conference can also be used to explain what will occur at the end of placement, whether or not a job is obtained (see FECA PM 2-0814).

(7) Employment: if the claimant accepts a position which does not accurately reflect his or her wage-earning capacity (such as accepting part-time work when capable of full-time employment).

(8) Retirement/OPM election: whenever the claimant brings this issue up, so the CE can assess the claimant's intentions and explain the process and the claimant's rights, responsibilities, and consequences if non-cooperation occurs prior to an election of OPM benefits.

e. Change in Case Status. The CE should notify the RS by short memo of any change in case status, such as the termination or suspension of compensation, or any information in the record which may directly affect the rehabilitation effort (e.g., medical evidence establishing no work-related residuals). The RS will then provide guidance to the RC.

f. Inquiries from Claimants. Claimants will sometimes query the RS or the RC about matters in the domain of the CE, such as compensation entitlement or medical authorization. Similarly, the CE may receive inquiries about vocational rehabilitation matters. Both rehabilitation and claims personnel are responsible for referring the claimant to the proper individual when issues arise which are not in the domain of the party addressed. No attempt should be made to address questions outside one's own area of expertise and responsibility.

15. Managing Medical Issues During Rehabilitation.

When a case is in vocational rehabilitation, many different types of medical issues may arise throughout the process which can impede the rehabilitation effort on a temporary or long-term basis. Although the vocational professionals (RC and RS) play an important role in the rehabilitation effort, medical issues are within the purview of the CE. Since a claimant may provide new medical documentation to an RC which may impact the rehabilitation program, it is important that all parties communicate with one another during the vocational rehabilitation effort to quickly and efficiently resolve outstanding medical issues.

a. CE Responsibilities. The CE has overall charge of the case and makes decisions based on the medical evidence of record and the professional recommendations of the RS and RC.

(1) Once a case is referred to vocational rehabilitation, the CE should continue to monitor the medical evidence and medically manage the claim. The CE should advise the RS immediately if there is a change in the claimant's medical status, particularly if it will have an impact on the vocational rehabilitation effort.

(2) The CE should read RC reports and query the RS if the reports demonstrate that the RC is focusing on vocational goals which do not appear to be in line with the claimant's medical limitations.

(3) The CE should promptly address medical issues raised by the RS, RC, or injured worker which will delay the development or continuation of a rehabilitation plan. In particular, the CE must act quickly when impediments to rehabilitation are reported. Examples of this include a change in the claimant's work restrictions or the development or treatment of a concurrent condition which interferes with the rehabilitation process.

(4) The RS and RC will generally not supervise extensive medical programs, with the exception of ORPs and substance abuse programs. Therefore, it is the CE's responsibility to monitor and promptly develop the medical evidence, as appropriate, including any changes in work limitations, changes in the weight of the medical evidence, the acceptance of consequential or additional medical conditions, or the scheduling of second opinion and/or referee medical examinations.

b. RC Responsibilities.

(1) The RC should immediately notify the CE and RS if the claimant indicates a change in his or her medical condition.

(2) The RC should provide the CE and RS with a copy of any new medical documentation that the claimant provides, paying particular attention to medical evidence that may change the established work tolerance limitations and the direction of the rehabilitation effort. Under certain circumstances the RC may contact the claimant's treating physician to discuss work limitations in order to expedite any necessary clarification needed to move forward. However, it is ultimately the CE who determines whether changes to the accepted work tolerance limitations are warranted based on the medical evidence of record.

(3) The RC should notify the CE and RS of any instances of non-cooperation based on medical issues so that the CE may act promptly to resolve potential impediments to the rehabilitation process.

c. RS Responsibilities.

(1) The RS should monitor RC reports for changes in the claimant's medical status and inform the CE, via OWCP-3 memo, a Rehabilitation Action Report, or similar documentation, if clarification of the medical evidence is needed at any time during the rehabilitation effort.

(2) The RS should provide guidance to the RC on how to handle a change in the claimant's medical status. Since the CE is the final authority on the weight of medical evidence, the RS must counsel the RC to ensure that the RC does not unnecessarily stall the rehabilitation effort unless the CE has determined that the new evidence establishes a significant change to the work tolerance limitations.

(3) The RS should promptly communicate to the CE any medical issues raised by the RC so that action may be taken to resolve such issues as quickly as possible.

d. Urgency of Actions. The rehabilitation effort could be delayed unnecessarily if the CE does not address and resolve medical issues quickly and thoroughly. The CE should act promptly to resolve issues identified by the RS or RC that are impeding the rehabilitation effort. Such issues include, but are not limited to, the following: the claimant's medical situation (work-related or non-work-related) appears to have changed significantly, or the claimant stops work after being reemployed because of a change in medical condition brought on by the return to work.

e. Effectively Resolving Medical Issues. The RS must defer to the CE on medical issues, and make sure that the RC does the same, in order to avoid creating conflicts in the medical evidence.

(1) Work limitations will be provided to the RC (or obtained in the course of an ORP) and should be used as a basis for planning the rehabilitation effort. Unless specifically authorized to contact the attending physician by an indication on the referral, the RC must refer any questions about work limitations to the CE.

(2) If the injured worker reports a recurrence of disability, introduces more severe restrictions, or provides other medical information (e.g., pregnancy, the need for physical therapy or other treatment, the emergence of a non-work-related medical condition or surgery) which would ultimately affect the rehabilitation plan, the RC should tell the injured worker to provide a medical report, and notify the district office. Rehabilitation should proceed on schedule unless the CE agrees that the medical situation has changed. If this occurs, the CE and RS can discuss whether to interrupt the rehabilitation effort or begin medical rehabilitation (see paragraphs 12 and 13 of this chapter).

(3) The CE should appropriately develop any questions regarding the nature and extent of injury-related disability, work limitations, or medical treatment plans with the attending physician, or a second opinion or referee specialist, if necessary, until a resolution is obtained. Formulation of direct and appropriate medical questions to the appropriate medical provider is crucial to this effort.

(4) If a second opinion or referee examination is arranged during the vocational rehabilitation effort, the CE should advise the RS. Also, the CE should immediately advise the RS of any change in the weight of medical evidence, as it affects work limitations or injury-related disability.

16. **Effects of Substance Abuse.**

Inappropriate use of drugs, whether legal or illegal, may complicate recovery from other medical conditions and hinder a claimant's return to work. Substance abuse may come to light from medical reports, contacts with the FN or RC, or through direct communication with the claimant. Actions to be taken, regardless of whether the Office has accepted it as work-related, are outlined below.

a. Treatment. Where substance abuse or addiction prevents a claimant from entering a vocational rehabilitation program, continuing with such a program once it has begun, or returning to work, the RC or RS may recommend participation in a drug treatment plan. The CE (not the RS or RC) is responsible for authorizing such care where necessary based on the medical evidence of record (e.g., the recommendation of the attending physician).

Such a program may be approved even if the Office has not accepted the substance abuse as related to employment.

(1) Ordinarily, inpatient care will be limited to a one-time 28-day stay at a reputable facility, though in unusual circumstances additional inpatient care may be authorized (see FECA PM 3-0400). The facility selected should be within 25 miles of the claimant's residence wherever feasible.

(2) Outpatient treatment may be recommended by itself or as a follow-up measure to inpatient care. Such treatment may be authorized when recommended by the attending physician, as may medications prescribed to alleviate the effects of addiction. Likewise, counseling in a group setting may be undertaken at OWCP expense.

b. Effect on Vocational Rehabilitation. The CE, or the RS on request of the CE, should advise the claimant of the terms of the referral before treatment begins. In particular, the claimant should be notified that non-completion of the program, or continued abuse of the substance after the treatment ends, may result in suspension of compensation benefits under 5 U.S.C. 8113 at the salary level of the job which is the goal of the vocational rehabilitation plan. Any suspension of benefits will continue until the claimant reenters a program and/or discontinues use of the substance.

If the effort is not successful, the claimant's compensation should be determined in accordance with paragraph 17 of this chapter, according to the claimant's status in the vocational rehabilitation process.

17. **Non-Cooperation and Sanction Decisions.**

Section 8104 of the FECA provides the authority for OWCP to direct an individual to undergo vocational rehabilitation, and section 8113 allows the Office to prospectively reduce compensation in accordance with a claimant's wage-earning capacity if he or she refuses, without good cause, to undergo vocational rehabilitation. The sanction remains in effect until the individual in good faith complies with the rehabilitation effort.

20 C.F.R. §10.519 prescribes what action OWCP will take if an employee refuses to undergo vocational rehabilitation. If a suitable job has been identified, OWCP will reduce compensation "…based on the amount which would likely have been his or her

wage-earning capacity had he or she undergone vocational rehabilitation." If a suitable job has not been identified, "…in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's compensation accordingly."

A claimant may fail to cooperate with vocational rehabilitation efforts in various ways. General examples of non-cooperation include lack of response to letters or phone calls from the RS or RC; failure to show up for appointments, interviews, or testing (e.g., vocational testing, functional capacity evaluation) arranged by the RC; and failure to attend an approved training program.

The RC must fully document any non-cooperation on the part of the injured worker and submit reports to the RS for immediate handling. The RS will inform the CE via OWCP-3 (or equivalent) of the claimant's non-cooperation. When an injured worker refuses or impedes the rehabilitation process, the CE must intervene (e.g., issuance of warning letter, conference call, or both). The type of intervention depends on the current stage of the vocational rehabilitation effort.

a. Refusing or Impeding Placement Previous Employer. An RC may be asked to work with the EA to determine if the agency will be able to identify work within the injured worker's limitations.

If the claimant impedes the rehabilitation process prior to a job being offered, the CE will treat this as non-cooperation with the rehabilitation process. Examples of this include failing to meet with the RC, refusing to show up for a scheduled FCE, etc.

If the injured worker refuses or impedes the rehabilitation process during this early phase, and the medical evidence indicates that the claimant does have the ability to work, the CE should issue a letter to the injured worker, advising that failure to cooperate with the vocational rehabilitation effort will result in a reduction of monetary compensation benefits. This letter should provide the claimant with 30 days to begin cooperating with the vocational rehabilitation effort or show good cause for refusing to cooperate. Release of this letter satisfies the requirement to issue a pre-reduction notice to the claimant.

If 30 days have passed since the warning letter was issued and no response is received, or if the injured worker does not begin or resume a good-faith effort to cooperate, the CE should issue a formal decision reducing compensation to zero under 5 U.S.C. 8113(b) and 20 C.F.R. §10.519(c), which states in part that "…in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's compensation accordingly."

If an offer of suitable employment has been made and the claimant refuses to accept the position, this is not failure to cooperate with vocational rehabilitation efforts. This is failure to accept a suitable job, subject to sanctions under section 8106 of the FECA. The CE should refer to FECA PM 2-0814 for appropriate action to take in this

situation.

b. Refusing or Impeding Plan Development. Specific instances of non-cooperation during this phase of vocational rehabilitation include: failure to appear for the initial interview; failure to attend meetings with the RC; failure to undergo an FCE, including failure to put forth optimum effort during the FCE; failure to undergo vocational testing and other work evaluations, including lack of response or inappropriate response to directions during testing; and failure to respond to the RC's telephone calls or written notices. Non-cooperation also includes failure to begin or continue pre-vocational training, such as English lessons for those who lack command of the language, or classes for a General Equivalency Diploma (GED) for those without a high school education.

If the claimant is in plan development and the file contains the documentation needed in order to make a determination on the claimant's wage-earning capacity, compensation should be reduced based on the claimant's ability to earn wages at the time of the sanction decision. If the CE is unsure about whether the evidence of record is sufficient, the RS should be requested to provide a recommendation on the claimant's WEC based on the evidence of record.

If this documentation is not yet of record and/or the RS is unable to provide it, then the compensation should be reduced to zero.

In either case, the CE will release a letter to advise the injured worker to begin or resume a good-faith effort to cooperate with the RS, or show good cause for refusing, within 30 days. (See e. below regarding evaluating reasons for non-cooperation.) This letter also satisfies the requirement to provide a 30-day pre-reduction notice.

c. Refusing or Impeding Training. Specific instances of non-cooperation during this phase of vocational rehabilitation include: failure to attend classes; failure to apply appropriate effort to succeed in such classes; failure to maintain a "C" average; and failure to undergo training after a training program has been approved.

If the claimant refuses or impedes rehabilitation training, the CE shall notify the injured worker, in writing, of the provisions of 5 U.S.C. 8113(b) and direct the injured worker to apply for, participate in, or resume participation in the training program. The letter should advise the injured worker to comply or provide a written explanation of his or her failure to comply within 30 days, or the provisions of 5 U.S.C. 8113(b) will be applied and benefits will be reduced based on the jobs targeted in the approved training plan. This letter satisfies the requirement to provide a 30-day pre-reduction notice.

d. Refusing or Impeding Placement New Employer. When placement efforts with a new employer are to begin, the CE should advise the injured worker by letter that OWCP will provide 90 days of placement assistance and that at the end of that 90-day period his or her WEC will be based on either (1) earnings from the new position; or (2) earnings for the job for which placement was attempted. (The 90

days is calculated from the date placement services begin as documented by the RS.)

It is important to note that non-cooperation with vocational rehabilitation during the placement stage does not generally result in a sanction decision under 5 U.S.C. 8113(b). If non-cooperation occurs during placement, the RS should request that the RC submit a final report and list the jobs for which placement was being attempted (i.e., provide updated labor market surveys, if necessary, including current pay information). Continuing placement services for the full 90-day period is not required if the claimant has not cooperated. Upon receipt of this information, the CE should prepare a pre-reduction notice determining the injured worker's WEC prospectively pursuant to 5 U.S.C. 8115 [not 8113(b)] based on one of the selected positions. This notice should be completed within 30 days of receipt of the OWCP-3 (or equivalent) from the RS, verifying that the selected positions are available in sufficient numbers. After considering any response to the pre-reduction notice, the CE should issue a final decision, if appropriate.

If the injured worker elects OPM benefits in lieu of cooperating with the vocational rehabilitation effort, the final decision reducing compensation based on prospective earnings must still be issued (see paragraph 18 of this chapter). It is necessary for the CE to establish the level of compensation entitlement in accordance with 5 U.S.C. 8115 so that any future, retroactive compensation will be paid at the proper established WEC instead of at the rate for total disability. The WEC decision will stand unless the injured worker meets one of the three valid reasons for WEC modification (see FECA PM 2-0814).

e. Evaluating Reasons for Lack of Cooperation. Given the variety of reasons which injured workers may offer for non-cooperation, and the variety of circumstances in which these reasons may be offered, it is impossible to establish a definitive list of acceptable and unacceptable reasons for lack of cooperation. In general, however, the injured worker is expected to treat the vocational rehabilitation effort as seriously as employment, and reasons for lack of cooperation should be considered in this light. A situation which would be considered a valid reason for absence from work (e.g., an illness) may be considered good cause for failure to cooperate with vocational rehabilitation for a reasonable period of time.

The specificity of the reasons offered and the injured worker's diligence in advising the RC of the problem should also be considered in evaluating reasons offered. Moreover, the CE must consider how much the specific instance(s) of failure to cooperate will affect the overall success of the vocational rehabilitation effort.

The injured worker may cite a change in his or her medical condition as a reason for not cooperating. In this situation, the CE should act promptly to resolve any potential medical issues that may affect the vocational rehabilitation effort (see paragraph 15 of this chapter).

f. Issuing Sanction Decisions under 5 U.S.C. 8113(b). As noted earlier in this section, the appropriate sanction for refusing a suitable job offer from the previous

employer comes under 5 U.S.C. 8106, and the appropriate decision for a claimant who refuses or impedes rehabilitation during the placement new employer (PNE) phase is a rating of the claimant's WEC under 5 U.S.C. 8115. Otherwise, sanctions for failure to cooperate in the rehabilitation process come under 5 U.S.C. 8113 (b), discussed below.

> Note: Decisions issued under 8106(b) and 8115 are different in that promises of "cooperation" after one of these decisions will not alter the final decision once it has been issued, and the grounds for reversal of those decisions are based on suitability of the job under 8106 and whether the WEC under 8115 should be modified.

Decisions issued under 5 U.S.C. 8113(b) can be affected if the claimant demonstrates cooperation after the decision is issued. If 30 days have passed since the warning letter was issued and no response is received, or if the injured worker does not begin or resume a good-faith effort and fails to provide good cause, the CE shall issue a formal decision reducing compensation under 5 U.S.C. 8113(b). Application of sanction decisions under 5 U.S.C. 8113(b) will result in suspension or reduction of compensation unless, and until, the claimant demonstrates cooperation with vocational rehabilitation efforts. This is true even when the next opportunity for actual cooperation will not occur for several months and the injured worker has stated that he or she will, in fact, comply with OWCP's requirements.

The decision should be tailored to the specific stage of the vocational rehabilitation process (e.g., plan development or training) and it should address the following:

(1) The nature of the specific failure or impedance;

(2) The contacts or dialogue among all parties, including the injured worker, the RC, the RS, the CE, and the vocational entity in question (e.g., the testing facility or company where the injured worker had an interview);

(3) The contents and date of the warning letter;

(4) Any reasons advanced by the injured worker for failure to cooperate. Each reason should be evaluated according to the criteria discussed in paragraph (e) above;

(5) An explanation why the injured worker's failure to cooperate was without good cause, and that either:

(a) The rehabilitation effort would have resulted in a return to work with no loss in WEC; or

(b) Cooperation with the rehabilitation effort would probably have substantially increased the injured worker's earnings.

The case status should remain PR, even if compensation is reduced, since no formal

rating of the claimant's WEC has been issued.

If the injured worker later complies with the Office's direction to undergo vocational rehabilitation after a formal decision has been issued reducing compensation under Section 8113(b), compensation should be reinstated prospectively at the previous rate. Health benefits and life insurance coverage, if applicable, should be reinstated *retroactively* to the date of termination and the premiums due for the period of reduction should be deducted from the continuing compensation beginning with the date of reinstatement.

The effective date of reinstatement of the previous rate of compensation should be the date the injured worker indicates in writing his or her intent to comply. However, the intent to cooperate must be confirmed by the RS or RC (e.g., the injured worker has actually contacted the RC or RS to begin or resume vocational rehabilitation efforts, or has scheduled and/or attended interviews or testing, etc.) before compensation is reinstated.

g. Multiple Instances of Non-Cooperation. An injured worker who fails to cooperate with OWCP more than once during the course of the vocational rehabilitation process should not be rated for an LWEC (unless the criteria are met for an 8115 decision as noted earlier in this paragraph). Rather, he or she should be given progressively more serious sanctions for the second and subsequent instances of non-cooperation if he or she does not resume cooperation after issuance of a warning letter and good reasons for failure to cooperate are not provided.

Example: Early in January, the injured worker repeatedly, and without explanation, fails to appear for vocational testing, and, after appropriate warning and assessment of the response, compensation is suspended to zero at the end of February. In mid-March, the injured worker professes willingness to cooperate, and actually does undergo the testing as directed, beginning in April. The CE, as a result, reinstates compensation retroactively to mid-March, after the testing is completed.

A plan is developed, and OWCP approves a one-year training program for the injured worker to begin in September. The injured worker misses the deadline for registration, and, again, after appropriate warning and assessment of the response, compensation is reduced in October (at the rate for partial disability, reflecting the job for which the training program is to prepare the injured worker). In mid-November, the injured worker again expresses willingness to resume cooperation, but compensation is not reinstated until the CE receives confirmation that the injured worker has registered for the semester in January of the following year. The date of reinstatement of compensation (at the rate of total disability) is the date the injured worker registered for the course, not before.

In February, one month after school begins, the RC reports to OWCP that the injured worker has been absent from classes for two weeks without explanation. A warning letter is issued, but the injured worker does not reply to it, and compensation is once again reduced (to the partial disability rate) in March 2011. The injured worker immediately contacts OWCP, promises to resume attendance, and promptly does so.

Instead of accepting the return to school as a demonstration of cooperation, however, OWCP determines that in light of previous instances of non-cooperation, the injured worker must complete the semester (which ends in April) before compensation payments are resumed (at the rate of total disability).

18. **Election of OPM (Office of Personnel Management) Benefits During Vocational Rehabilitation.**

OWCP is a return-to-work program and not a retirement program; however, if eligible, the claimant may have a right under law to choose retirement benefits in lieu of OWCP benefits (FECA PM 2-1000). When reviewing instances of non-cooperation in conjunction with an OPM election during the vocational rehabilitation process, it is important to focus on the behavior and level of non-cooperation. Sanctions may apply to the non-cooperative behavior but not to the choice to elect OPM.

a. A conference may be helpful any time retirement is brought up during the rehabilitation process. The CE should consider scheduling a conference to assess the claimant's actual intent, since many times the claimant may be simply exploring options. Other times the claimant may not understand that OWCP is a return-to-work program and not a retirement program. A conference provides the opportunity to create a plan of action for both the claimant and the CE. After the conference, an election offer should be issued if the claimant states this is his or her choice.

Despite issuing an election letter, the CE should pursue case management and rehabilitation to its logical conclusion. Sending the election letter does not guarantee OPM election. Until the claimant actually submits a signed election form choosing OPM benefits, he or she is required to participate fully in rehabilitation or be subject to the sanction process.

b. If the claimant continues to cooperate until the actual election form is signed and received by OWCP, the election is at the temporary total disability (TTD) amount.

c. If the claimant does not cooperate during the election process, any behavior which is deemed to be non-cooperation will be subject to sanctions pursuant to 5 U.S.C. 8113. A non-cooperation sanction under 5 U.S.C. 8113 may not be initiated once a claimant has officially elected OPM benefits. It may only be finalized following an OPM election if the warning letter was issued while the claimant was in receipt of FECA benefits.

If a sanction is applied prior to receipt of the actual election, the election is at the reduced amount pursuant to the sanction. When a warning is issued before the claimant elects OPM benefits, and the claimant continues to be uncooperative up to the point of the election, it is appropriate to issue the final sanction under 5 U.S.C. 8113, even if it is issued after the election is signed. In the decision, the CE should focus on the reasons that the claimant's behavior was determined to be non-cooperative and must document the selection of a zero or reduced LWEC rating, taking into consideration the claimant's condition and not the choice to elect OPM benefits.

If the claimant later decides through a subsequent election to resume OWCP benefits, he or she returns to OWCP at the zero or reduced rate (suspension amount) for the retroactive period and only at TTD prospectively at the point in which cooperation resumes (effective the date the injured worker indicated in writing his or her intent to comply).

Note: If the evidence warrants, the CE should consider issuance of a WEC in accordance with 5 U.S.C. 8115, rather than a sanction under 5 U.S.C. 8113. See below.

d. If the claimant fails to participate during Placement, the election is offered at the TTD amount with an explanation of the WEC decision to follow. The CE should then pursue resolution with a Notice of Proposed Reduction and a formal constructed LWEC decision pursuant to 5 U.S.C. 8115 with appeal rights.

Any future retroactive compensation, if the claimant later chooses to elect OWCP benefits once again, would be payable at the WEC rate. If a final WEC decision pursuant to 8115 is issued, it can only be modified for one of the three established criteria outlined in PM 2-0814.

19. Possible Outcomes of Vocational Rehabilitation.

The goal of the vocational rehabilitation effort is to ultimately return all injured federal employees to some form of gainful work, with the previous employer or in the private sector. However, there are times when vocational rehabilitation efforts are not successful and do not result in a return to work. In some situations, appropriate sanctions must be applied because the injured worker refused a suitable job or failed to cooperate with rehabilitation efforts (see FECA PM 2-0814 and paragraph 17 of this chapter). In other situations, the claimant's WEC must be determined on the basis of a position deemed suitable but not actually held. (See FECA PM 2-0814 for more specific details on issuing WEC decisions). No matter the situation, the CE should issue appropriate entitlement decisions whenever possible to complete the rehabilitation process.

a. Return to Work with the Previous Employer. When the employee cannot return to the DOI job because of disability due to the work-related injury or disease, he or she may return to alternative or limited duty employment with the previous employer. After the claimant has been working for 60 days, the CE should determine whether the claimant's actual earnings fairly and reasonably represent his or her WEC. If so, a formal decision should be issued within 90 days of the date of return to work.

b. Refusal of Suitable Work with the Previous Employer. Section 5 U.S.C. 8106(c) provides a severe penalty against workers who refuse offers of suitable work, or who abandon suitable work without good cause. After appropriate warning letters have been provided to the claimant, and the refusal of suitable work continues, the CE should prepare a formal decision which provides full findings of facts as to why claimant's reasons for refusing the job are deemed unacceptable and terminate compensation. Such a decision should not be modified even if the claimant's medical condition later deteriorates and he or she claims a recurrence of total disability.

c. Return to Work with a New Employer (other than the EA). Sometimes the claimant will return to work but not with the original employer. After the claimant has been working for 60 days, the CE will determine whether the claimant's actual earnings fairly and reasonably represent his or her WEC. If so, a formal decision should be issued within 90 days of the date of return to work. If not, the CE should consider whether a constructed WEC decision is appropriate.

d. Constructed WEC Decisions. If the claimant does not locate employment at the end of the vocational rehabilitation process, or if the claimant's actual earnings are not representative of his or her capacity to earn wages, further determination must be made based on the claimant's ability to work in a selected position. The test for making this type of decision is whether the claimant's WEC based on the selected job appears reasonable, giving due regard to the factors specified in 5 U.S.C. 8115 (i.e., the nature of the injury; the degree of physical impairment, including impairment resulting from both injury-related and pre-existing conditions; the claimant's usual employment; the claimant's age; qualifications for other employment, including education, previous employment, and training as well as work limitations imposed by the injury-related and pre-existing impairments; and the availability of suitable employment.)

e. Other Outcomes of Rehabilitation.

(1) Where rehabilitation services are under way and the CE determines that injury-related disability has ceased, it is proper to issue a pre-termination notice. As the claimant's response may overcome the initial determination to terminate compensation, OWCP should continue rehabilitation services during the notice period until a formal decision is issued. Pre-termination notices and formal decisions are discussed in PM Chapter 2-1400.

(2) Specific sanctions for non-cooperation with rehabilitation efforts may be applied as detailed in paragraph 17 of this chapter.

(3) The severity of the claimant's medical condition (work-related or non-work-related) may change or worsen during the rehabilitation process. If the medical limitations from the accepted injury-related condition(s) and any pre-existing medical condition(s) subsequently prohibit a return to all gainful employment, the CE's concurrence with the infeasibility of continued reemployment efforts is needed for closure of rehabilitation efforts.

(4) A claimant may elect OPM at any time during the rehabilitation process. The CE should consider the specific stage of the rehabilitation effort and refer to paragraph 18 of this chapter for detailed guidance concerning further actions that should be taken in each instance.

2-0813 Exhibit 1: Physical Demand Definitions

DFEC has adopted the following definitions from the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles (where applicable), which should be used when comparing the established work restrictions to the physical requirements of positions identified in the Dictionary of Occupational Titles. These definitions indicate the absence or presence and frequency of the physical demand components requested on the OWCP-5b and OWCP-5c.

1. STRENGTH LEVEL

Sedentary Work – Sedentary Work involves exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs may be defined as Sedentary when walking and standing are required only occasionally and all other Sedentary criteria are met.

Light Work – Light Work involves exerting up to 20 pounds of force occasionally or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job/occupation is rated as Light Work when it requires: (1) walking or standing to a significant degree; (2) sitting most of the time while pushing or pulling arm or leg controls; or (3) working at a production rate pace while constantly pushing or pulling materials even though the weight of the materials is negligible. (The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.)

Medium Work – Medium Work involves exerting 20 to 50 pounds of force occasionally or 10 to 25 pounds of force frequently or an amount greater than negligible and up to 10 pounds constantly to move objects. Physical demand requirements are in excess of those for Light Work.

Heavy Work – Heavy Work involves exerting 50 to 100 pounds of force occasionally, or 25 to 5O pounds of force frequently, or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.

Very Heavy Work – Very Heavy Work involves exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.

Limits of Weights Lifted/Carried/Pushed/Pulled

Rating	Occasionally	Frequently	Constantly
Sedentary	* - 10	*	N/A
Light	* - 20	* - 10	*

Medium	20 - 50	10 - 25	* - 10
Heavy	50 - 100	25 - 50	10 - 20
Very Heavy	100 +	50 +	20 +

* = negligible weight; N/A = Not Applicable

The range excludes the lower number and includes the higher number, i.e., the range 10 - 25 excludes 10 (begins at 10 +) and includes 25.

Presence and/or Frequency of Other Physical Demands

This chart should be referenced to determine the frequency of demands for the remaining physical components of a given job.

Code	Frequency	Definition	Max hrs./8 hr. day
N	Not Present	Activity/condition does not exist	0
O	Occasionally	Activity/condition exists up to 1/3 of the time	2 hrs. 40 min.
F	Frequently	Activity/condition exists from 1/3 to 2/3 of the time	5 hrs. 20 min.
C	Constantly	Activity/condition exists 2/3 or more of the time	8

2. REACHING

Extending hand(s) and arm(s) in any direction, including overhead reaching or reaching above shoulder level.

3. TWISTING

Turning, twisting, contorting, or flexing the torso in any direction towards the right or left.

4. BENDING/STOOPING

Bending body downward and forward by bending spine at the waist, requiring full use of the lower extremities and back muscles.

5. OPERATING A MOTOR VEHICLE AT WORK

Driving any vehicle during the performance of one's duties.

6. REPETITIVE MOVEMENTS OF ELBOWS (HANDLING)

Seizing, holding, grasping, turning, or otherwise working with hand or hands using the whole arm.

7. REPETITIVE MOVEMENTS OF WRISTS (FINGERING)

Picking, pinching, or otherwise working primarily with fingers and wrists rather than the whole arm as in handling.

8. SQUATTING (CROUCHING)

Bending body downward and forward by bending legs and spine.

9. KNEELING

Bending legs at knees to come to rest on knee or knees.

10. CLIMBING

Ascending or descending ladders, stairs, scaffolding, ramps, poles, and the like, using feet and legs or hands and arms. Body agility is emphasized.

2-0813 Exhibit 2: Environmental Conditions Definitions

The DFEC has adopted the following definitions from the Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles, which should be used when comparing the established work restrictions to the environmental conditions for positions identified in the Dictionary of Occupational Titles. These definitions indicate the absence or presence and frequency of the environmental components requested on the OWCP-5b.

Presence and/or Frequency of Environmental Condition Components
This chart should be referenced to determine the frequency of exposure to the listed environmental components.

Code	Frequency	Definition	Max hrs./8 hr. day
N	Not Present	Activity/condition does not exist	0
O	Occasionally	Activity/condition exists up to 1/3 of the time	2 hrs. 40 min.
F	Frequently	Activity/condition exists from 1/3 to 2/3 of the time	5 hrs. 20 min.
C	Constantly	Activity/condition exists 2/3 or more of the time	8

1. EXPOSURE TO TEMPERATURE EXTREMES

Exposure to outside atmospheric conditions and/or non weather-related hot and/or cold temperature.

2. EXPOSURE TO AIRBORNE PARTICLES

Exposure to such conditions as dusts, smoke, and poor ventilation that affect the respiratory system, eyes, or the skin.

3. EXPOSURE TO GASES/FUMES

Exposure to such conditions as fumes, noxious odors, mists, and gases that affect the respiratory system, eyes, or the skin.

4. EXPOSURE TO ELECTROMAGNETIC RADIATION

Exposure to electromagnetic radiation that affects cardiovascular devices.

2-0814 REEMPLOYMENT: DETERMINING WAGE-EARNING CAPACITY

12. Termination of Employment	05/97	97-10
	07/97	97-17
	10/09	10-01
13. Effect of Federal Reemployment on Retirement Status	06/96	96-20
	10/09	10-01

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

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 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 (see FECA PM 2-0901.15) 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 Rehabilitation Specialist (RS) to identify two suitable jobs and applying the factors set forth under 5 U.S.C. 8115(a) (see paragraph 8 below). Only one job may ultimately form the basis of a WEC determination.

(2) The CE will determine the claimant's monetary entitlement using the Shadrick formula (see FECA PM 2-0901.15). 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. In cases involving performance-based pay systems (pay banding), where a specific grade and step were not assigned to the date of injury job, the CE will first need to determine the claimant's date of injury pay rate as a percentage of the appropriate band; see FECA PM 2-0901.15.

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. See William D. Emory, 47 ECAB 365 (1996) (Employee worked intermittently as a babysitter for his grandson. ECAB held that OWCP improperly determined his wage-earning capacity effective 1990 based on his actual earnings as a babysitter).

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, 2002 that the claimant, injured

on June 5, 1997, returned to work on September 1, 1998 and worked intermittently through September 1, 2002 when he ceased work. On September 1, 2002 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, 1998 through September 1, 2002, 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 is generally to be considered appropriate where an investigation reveals that a claimant held private employment and had substantial earnings which were not reported to OWCP or were otherwise not used in adjusting compensation entitlement. (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 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 should enter appropriate codes in the Rehabilitation Tracking System, if the claim is being tracked. The Disability Management application should also be updated with return to work information.

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). See also J.E., Docket No. 08-1582 (issued March 3, 2009). ECAB held that it was inappropriate for OWCP to base appellant's wage-earning capacity on the constructed position of eligibility worker, as the position is a state or government position and there was no evidence as to whether the position was available in the general labor market.

a. Factors Considered. Under section 8115 (a), 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 Rehabilitation Counselor (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) (or OWCP specified equivalent) 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 (or OWCP specified equivalent) 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 under Section 8115 (a). 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 wage-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 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 2-1400.8).

(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 database. Thereafter, medical evidence should be requested on a regular basis and obtained at least every 3 years to monitor the claimant's physical condition and employment-related disability; and earnings information should be obtained 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 (or OWCP specified equivalent), 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. Pursuant to § 8148(b) of the FECA, benefits of individuals imprisoned as a result of a **felony** conviction shall be suspended as of the date of

imprisonment. The implementing regulations (20 C.F.R. § 10.18) provide that the convicted individual forfeits all rights to compensation during the period of incarceration. See Danny E. Haley, 56 ECAB 393 (2005). However, during periods that a claimant's compensation is suspended under section 8148(b) for a felony conviction, the claimant's dependents are entitled to a percentage of his compensation. See Cheri Cortinas, guardian of Savannh Speiser, Docket No. 02-363 (issued April 21, 2003). See also PM Chapter 2-1400.12.

Claimants not convicted of felonies do not lose entitlement to compensation payments simply because they are imprisoned. Such cases are handled according to the same criteria as any other case, insofar as possible. 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.

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 (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 below:

(1) Where the claimant elected to receive disability retirement rather than accept suitable work. See Roy E. Bankston, 38 ECAB 380 (1987) (ECAB affirmed the OWCP's termination of compensation where the claimant voluntarily retired two and a half years after he returned to work, and there was no evidence to indicate that he retired because of disability or health reasons). See Stephen R. Lubin, 43 ECAB 564 (1992) (ECAB noted that the employee's election to receive retirement benefits was not a valid reason for refusing an offer of suitable work). See also B.C., Docket No. 08-1274 (issued May 11, 2009) ("To the extent that appellant refused the position because she was pursuing a disability retirement, the Board notes that retirement is not an acceptable reason for refusing an offer of suitable work.").

(2) Where the claimant resigned a modified light-duty position without good reason. See Arquelio Pacheco, 40 ECAB 277. See also Jerry Inman, Docket No. 03-476 (issued April 24, 2003) (The claimant alleged that

coworkers had treated him poorly when he returned to the previous light-duty position and that the employing establishment failed to provide him with information regarding his status in the event of a reduction-in-force. ECAB held that issues of job security were not acceptable reasons for refusing an offered position.).

(3) Where the claimant resigned from his limited-duty position "because it was going nowhere" and he preferred to go back to college. See James E. Kale, Docket No. 88-2031, issued May 22, 1991. See also Donald A. Reynolds, Docket No. 00-2682, (issued August 17, 2001) (At the time of his work stoppage, appellant indicated that he was resigning his position because he desired to finish his degree).

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 9 b(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 (also notifying the employing agency), 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 reasons for the abandonment are 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 materially changed;

(3) The claimant has been vocationally rehabilitated.

See Tamra McCauley, 51 ECAB 375, 377 (2000) (ECAB has held that once the wage-earning capacity of an injured employee is determined, a modification of such determination is not warranted unless there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated or the original determination was, in fact, erroneous).

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. Cases with an LWEC decision should not be treated as a claim for recurrence of disability; they should be evaluated for modification of the LWEC.

(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 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. See W.G., Docket No. 06-367 (issued December 27, 2006) (ECAB held that the psychology technician position was proper for a modification of an existing wage-earning capacity determination, as appellant was vocationally rehabilitated and employed in a new job earning at least 25 percent more than the position in which he was rated); But also see Mary Miklosz, Docket No. 05-1672 (issued June 9, 2006) (ECAB held that without a showing of additional qualifications obtained by appellant through retraining, it is improper to make a new loss of wage-earning capacity determination based on increased earnings).

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, 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. See Jack H. Mason, Docket No. 06-243 (issued June 20, 2006) (ECAB held that OWCP properly denied modification of appellant's loss of wage-earning capacity decision, as the evidence was insufficient to show that appellant could not perform the duties of his light duty position which was eliminated due to a RIF). See also Thomas A. Crow, Docket No.99-1455 (issued December 5, 2000) (ECAB, citing the implementing regulations at 20 C.F.R. § 10.509, held that appellant did not establish a recurrence of disability beginning when his job was eliminated in a RIF, as the medical evidence was insufficient to establish that he was no longer able to perform the physical requirements of the light-duty position he had held).

As noted in 20 C.F.R. 10.509, an employee generally will not be considered to have experienced a compensable recurrence of disability as defined in 20 CFR § 10.5(x) merely because his or her employer has eliminated the employee's light-duty position in a reduction-in-force or some other form of downsizing. When this occurs, OWCP will determine the employee's wage-earning capacity based on his or her actual earnings in such light-duty position if this determination is appropriate on the basis that such earnings fairly and reasonably represent the employee's wage-earning capacity and such a determination has not already been made. For the purposes of 10.509, a light-duty position means a classified position to which the injured employee has been formally reassigned that conforms to the established physical limitations of the injured employee and for which the employer has already prepared a written position description such that the position constitutes federal employment. In the absence of a "light-duty position" as described in this paragraph, OWCP will assume that the employee was instead engaged in non-competitive employment which does not represent the employee's wage-earning capacity, i.e., work of the type provided to injured employees who cannot otherwise be employed by the Federal Government or in any well-known branch of the general labor market.

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 2-814.7(e)). 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 and 2-811, 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 on 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 under the Federal Employee Retirement System (FERS). P.L. 98-21, Approved April 20, 1983 (97 Stat. 65).

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. 26 U.S.C. 3121(b)(5)(B).

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.

d. The federal retirement laws were amended in October 2003 to address deficiencies with regard to the retirement benefits of Federal employees who are absent from their jobs for long periods because of workplace illnesses or injuries. Under the Civil Service Retirement System (CSRS) and the newer Federal Employees' Retirement System (FERS), when an individual receives workers' compensation benefits under subchapter I of chapter 81 of title 5, United States Code, and returns to duty under retirement coverage, that period of time is creditable service in the subsequent computation of retirement benefits. Under CSRS, the individual's retirement benefit is the same as if the individual had continued in employment during the period he or she was in receipt of workers' compensation. While FERS was designed in such a manner that the total retirement benefits are roughly equivalent to the CSRS benefit, it is a three-tier system that includes Social Security, the Thrift Savings Plan (TSP, a defined contribution tier), and FERS (a defined benefit tier). While the period in receipt of workers' compensation benefits is creditable toward the FERS benefit, the FERS tier represents only approximately one-half of the total retirement benefit. With regard to the other two tiers of benefits, no employer or employee contributions to the TSP are allowed by law and no wage credits are earned toward Social Security benefits during the period that an individual is in receipt of workers' compensation benefits. To correct that disadvantage for a FERS employee in that situation (since TSP and Social Security represent approximately 1 percent of post-retirement income for each year of service), the law employs the simple solution to increase the FERS retirement benefit by that amount (1 percent) for periods under workers' compensation. See 5 U.S.C. 8415 (l).

Note: A claimant who has questions concerning creditable time, restoration rights and other retirement/personnel matters should be directed to the employing agency or the Office of Personnel Management.

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

2-0900 DETERMINING PAY RATES

TABLE OF CONTENTS

2-0900-1 Purpose and Scope

1. Purpose and Scope. **This chapter addresses determination of pay rates for injured workers who meet the criteria as employees within the meaning of 5 U.S.C. 8101(1). It describes the steps for establishing pay rates, including the statutory basis of payment; the effective date of the pay rate; the elements of pay which are included in the pay rate, and those which are excluded; and how to establish daily, weekly, and monthly pay rates. The chapter also includes a section on special determinations (which are also addressed in various FECA Program Memoranda).**

Section 8101(4) defines "monthly pay" as “the monthly pay at the time of injury, or the monthly pay at the time disability begins, or the monthly pay at the time compensable disability recurs, if the recurrence begins more than 6 months after the injured employee resumes regular full-time employment with the United States, whichever is greater, except when otherwise determined under section 8113 of this title with respect to any period.” The monthly pay for wage loss compensation is subject to a minimum and maximum level of compensation that is set forth in 5 U.S.C. 8112. Section 8113 sets forth certain criteria for an employee employed in a learner’s capacity. Section 8114 sets forth various formulas for how to calculate the rate of pay and sets forth elements of pay such as overtime that must be excluded from pay rate calculations.

2-0900-2 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-6, CA-7, and CA-2a contain much useful information, the Claims Examiner (CE) must also consider any narrative evidence in file. To establish a pay rate, the CE should take the following steps:

a. Determine the Basis of Payment Under 5 U.S.C. 8114 and whether the claimant is a full-time, part-time, temporary, seasonal, casual, etc. worker. If the claimant worked the whole year prior to injury or would have done so but for the injury (Form CA-7, section 9b), this determination is straightforward. If not, however, the CE must investigate all sources of income to determine the claimant's "average annual earnings" before proceeding further. See paragraphs 3 and 4 below.

b. Determine the Effective Date of Pay Rate. The CE must next decide whether to set the pay rate as of the date of injury (DOI) (or death), the date disability began (DDB), or the date of recurrence (DOR). The pay rates on the date of injury and date disability began should be noted on Form CA-7, section 8. Pay rates for newly reported recurrences should be shown on Form CA-2a, while pay rates for previously accepted recurrences should be noted in the Compensation application of the Integrated Federal Employees’ Compensation System (iFECS). See paragraph 5 below.

c. Consider Inclusions and Exclusions from Pay Rate. The nature of the increment must be considered first. Commonly encountered increments are reported on Form CA-7, section 8. The CE should also review Form CA-1, CA-2, or CA-2a for evidence of entitlement to premium pay. If the increment can be included, the CE must determine how long it has been received and the amount of money that has been paid. See paragraphs 6-8 below.

d. Clarify Any Discrepancies. The employing agency (EA) or claimant may challenge, correct, or expand on the evidence in the original reports with respect to terms of employment, amount of pay, or types and amounts of increments.

(1) The CE must clarify any material discrepancies in the record before establishing a pay rate for compensation purposes. This can be done by

letter, secure e-mail with the employing agency to and from a government network, or by telephone call followed by written confirmation. Document the information received via telephone in the case file on a CA-110 pending receipt of written confirmation.

(2) Evidence submitted by an EA that is supported by records will usually prevail over statements from the claimant, unless such statements are supported by documentary evidence.

(3) When a discrepancy in the reported pay rates is identified, compensation should be paid based on the lower figure until the CE resolves the discrepancy. A provisional rate of GS-2, step 1, or the amount reached by multiplying the daily wage by 150 may be used if necessary. The eight hours per day used in the "150–formula" is based on a five-day work week, or 40 hours per week. Any adjustment should be included in a later payment. The CE should note use of a provisional or temporary rate in the compensation screen of iFECS and in the case record.

e. Decide on Daily, Weekly, or Monthly Basis. While disability claims may be paid on a daily basis under limited circumstances, most are paid on a weekly basis. All death claims are paid on a monthly basis. See paragraphs 9-11 below.

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, as well as other types of appointments or duty status.

a. Civil Service.

(1) Kinds of Appointments. The Office of Personnel Management (OPM) recognizes four kinds of appointments: career; career-conditional (essentially a probationary period); term (not to exceed four years, and with no career status); and temporary (not to exceed one year, with a one-year extension possible, and with no career status).

(2) Tours of Duty. OPM recognizes five tours of duty:

(a) Full-time (40 hours per week);

(b) Part-time (16-32 hours per week);

(c) Intermittent (no regularly scheduled hours);

(d) Seasonal (less than 12 months per year, with either a full-time, part-time, or intermittent schedule); and

(e) On-call (usually at least six months per year on an as-needed basis, with either a full-time or part-time schedule).

Items 20 and 21 on Form CA-1 and items 21 and 22 on Form CA-2 should show the employee's work schedule.

b. Postal Service.

(1) Kinds of Appointments. The Postal Service recognizes the same kinds of appointments as OPM. The Postal Service may differentiate these duties by use of different job titles such as Part-Time Flexible or Casual, and by the type of schedule the employees work.

(2) Tours of Duty. The Postal Service recognizes several types of tours of duty, depending on the kind of work performed. Review of Form PS-50 should clarify the tour of duty on the date of injury and kind of work performed.

An employee may work more hours than indicated by the tour of duty, but careful consideration of base pay versus overtime pay should be given to clarify the regular work schedule. In such cases, the pattern established by the actual number of hours worked or actual amounts of money earned takes precedence over the stated schedule or tour of duty in deciding which part of 5 U.S.C. 8114 to use in determining the pay rate.

Postal Service tours are distinguished as follows:

(a) Craft employees such as letter carriers and mail clerks, or other full-time employees, are paid under the Postal Service (PS) salary structure. These are full-time regular employees and work 40 hours per week.

(b) Part-time regular employees have a fixed schedule but work less than 40 hours per week.

(c) Full-time rural carriers are assigned to specific routes, each of which is evaluated at 36 to 48 hours per week, depending on the size of the route.

The salaries for full-time rural carriers are based on the evaluation of their routes. The Postal Service uses a formula to determine the evaluated salary, which may be based on an evaluation of between 36 and 48 hours per week. Salaries derived from routes which are evaluated at more than 40 hours per week are not considered to include overtime for rural carriers.

Rural carriers are not in an overtime status unless they actually work more than the number of hours stipulated in their contract for their route evaluation and are paid accordingly for overtime. The evaluated pay, therefore, is the pay rate for compensation purposes.

The salary for full-time rural carriers may vary over the life of the claim due to re-evaluations of the employee's assigned route. These changes will only affect the pay rate for compensation purposes on the date disability begins, or if the employee is performing regular work on a full-time basis at the time of a recurrence that qualifies for a recurrent pay rate. If the pay rate on the date disability begins or at the time of a qualifying recurrence is lower than the DOI pay rate, then the DOI pay rate is used to compute compensation.

If a change occurs during a period of disability, compensation continues to be based on the original pay rate.

(d) Rural carrier associates (RCA) are employed irregularly and paid When Actually Employed (WAE). Leave replacement workers, which include RCA's, relief carriers, and substitutes, can work any schedule. For rural carrier leave replacements, who are hired on a part-time basis to substitute for rural carriers and may work from one to six days in a given week, the pay rate should be established in accordance with 5 U.S.C. 8114(d).

(e) Part-time flexible employees, like RCA's, do not have a fixed schedule and can work any schedule up to 40 hours per week and are also paid WAE. Part-time flexible employees are not paid extra for holidays, as their basic pay rate includes an increment for holidays.

(f) Casual employees only work a guaranteed 89-day period, which may or may not be renewed by the Postal Service. A careful review of the employee's PS-50 should clarify the employee's entry on duty date for reference.

(g) Postal inspectors have scheduled work weeks of six days per week and are not paid overtime for the sixth day. These employees are included in the Executive and Administrative Salary (EAS) pay structure, which also covers executives, professionals, supervisors, postmasters, and technical, administrative and clerical employees.

(h) Postmasters (A-E) may work 40 hours per week over six days. Pay for the sixth day does not constitute overtime.

(i) Postal Career Executive Service (PCES) employees are paid an annual salary and may work any schedule with no overtime payable.

c. Military Sealift Command.

(1) Kinds of Appointments. Members of the Military Sealift Command (MSC) crew are assigned to a ship(s) which is usually based out of Norfolk, Virginia or San Diego, California. The duties the crew members perform,

which are dependent on the needs of the boat and the boat's specific mission(s), determine what extra pay they may earn.

(2) Tours of Duty and Types of Extra Pay Earned. The tour of duty for MSC crew members is dependent on the boat and the particular duties assigned. Tours of duty may be more than eight hours per day. All crew members are guaranteed a set base salary but may earn extra pay for items discussed under paragraph 6(b) below. Not every crew member will necessarily earn all of the allowable extra pay elements, and duties can change each day.

d. National Guard.

(1) Kinds of Appointments. National Guard members are required to be members of the Air and/or Army National Guard because this membership is contingent upon their civilian Federal employee status. This is considered an accepted dual status.

Federal employees who are not civilian members of the Air and/or Army National Guard are ineligible for this dual status because it is not a requirement for any other Federal employee to retain this dual Federal employment.

(2) Tours of Duty. Civilian members of the Air and/or Army National Guard normally work a set 40-hour work week but perform a two-week or 15-day drill duty each year in addition to monthly training assemblies.

An employee may also be recalled to duty for active Federal service under a Presidential "call" for a period not to exceed 270 days. Refer to paragraph 6(b) below for clarification when a civilian National Guard employee is entitled to compensation above his or her base salary.

e. Census Bureau. Census Bureau employees can be either full-time 40 hour per week regular employees, or may be hired every ten years to work in temporary appointments (not to exceed 180 days) as enumerators, crew leaders or clerks. Temporary positions such as enumerators historically average 4.5 hours per day, four days per week, but crew leaders or clerks can work more than this during the 180-day appointment period.

f. Federal Jurors. Grand Jurors can sit for up to 36 months but do not necessarily convene every day. They may hear evidence for many different cases. Petit Jurors participate in criminal and civil trials and normally serve for one trial only. See FECA PM 2-0802-20 for further details.

g. Firefighters.

(1) Kinds of Appointments. There are several categories of firefighters employed with the Federal Government:

(a) Full-time firefighters, such as those on military installations.

(b) Seasonal firefighters with the US Forest Service.

(c) Firefighters hired on an emergency basis to address specific critical incidents.

(2) Tours of Duty. Tours of duty may vary:

(a) Firefighters who normally work three 24-hour shifts per week. Most firefighters who work a 24-hour shift have a regular bi-weekly tour of 144 hours (six 24-hours shifts), consisting of 106 regular hours and 38 "firefighter overtime" hours.

(b) Firefighters with an extended regular tour built on top of a 40-hour basic workweek.

(c) Emergency firefighters who are typically employed with the Forest Service, National Park Service, and Bureau of Land Management. These employees are not "career seasonal" and are hired on an as-needed basis. Schedules often exceed eight hours per day and five days per week.

h. Department of Agriculture Co-op Employees. These employees work with the Department of Agriculture under a cooperative agreement with a non-Federal public or private organization. See paragraph 12 below.

i. Peace Corps. Each volunteer works in an assignment for a period of 27 months and is considered enrolled 24 hours per day during his or her enrollment period. See FECA PM 2-1700-4 for more information. Pay rates for volunteers are set forth in 5 U.S.C. 8142 (c).

j. Job Corps. Training offered by Job Corps for enrollees as young as 16 years can take from eight months to two years to complete. Subject to the statutory guidance and procedures set forth in FECA PM 2-1700-6, the employee is generally considered covered under the FECA 24 hours per day during this time frame. Pay rates for Job Corps students are set forth in 5 U.S.C. 8143.

k. Americorps VISTA. AmeriCorps itself is split into three main divisions, including AmeriCorps State and National, Volunteers in Service to America (VISTA), and National Civilian Community Corps (NCCC). Each member works for a minimum of one year and is generally covered under the FECA 24 hours per day during this time frame. See FECA PM 2-0802-30.

2-0900-4 Average Annual Earnings

4. Average Annual Earnings. This paragraph describes how to determine average

annual earnings. This determination, which depends on the nature and duration of the employment, must be made before establishing weekly and monthly pay rates.

The four methods provided by the FECA for making these determinations are set forth in 5 U.S.C. 8114(d)(1) through (d)(4) and are outlined briefly as follows:

Section 5 U.S.C. 8114(d)(1) is used if the employee worked substantially the whole year prior to the injury.

Section 5 U.S.C. 8114(d)(2) is used if the employee did not work substantially the whole year prior to the injury, but would have been employed for substantially a whole year had it not been for the injury.

Section 5 U.S.C. 8114(d)(3) is used if the employee was not employed for substantially the whole year and the employment would not have lasted for substantially the whole of the year.

Section 5 U.S.C. 8114(d)(4) is used when an employee works without pay or nominal pay.

When determining a pay rate, the above criteria should be considered in the order listed, so that only if the method prescribed in 5 U.S.C. 8114(d)(1) cannot be reasonably and fairly applied should the CE consider using the method stated in 5 U.S.C. 8114(d)(2), and so forth.

a. Whole-Year Employment – 5 U.S.C. 8114(d)(1).

5 U.S.C. 8114(d)(1) states,

(d) Average annual earnings are determined as follows:

(1) If the employee worked in the employment in which he was employed at the time of his injury during substantially the whole year immediately preceding the injury and the employment was in a position for which an annual rate of pay--

(A) was fixed, the average annual earnings are the annual rate of pay; or

(B) was not fixed, the average annual earnings are the product obtained by multiplying his daily wage for the particular employment, or the average thereof if the daily wage has fluctuated, by 300 if he was employed on the basis of a 6-day workweek, 280 if employed on the basis of a 5 1/2 -day week, and 260 if employed on the basis of a 5-day week.

Therefore, if the employee worked at least 11 months ("substantially the whole year") before the injury in the job held at the time of injury (see section 9(b) on Form CA-7 or item 19 on Form CA-6), the CE may accept the basic pay rate reported without further inquiry.

The following considerations also apply to section 5 U.S.C. 8114(d)(1):

(1) Career seasonal employment. This is an arrangement where the employee regularly works just part of a calendar year, usually for the same general period each year and at the same type of job. Such workers often perform highly specialized duties (e.g., forest firefighters, IRS tax examiners, forestry technicians).

(a) An employee who has worked in such a position during more than one calendar year by prior written agreement with the employer is considered to be a career seasonal employee. Such an employee is entitled to receive compensation on the same basis as an employee with the same grade and step who has worked the whole year.

(b) Information as to the status of the employee may appear on Form CA-7. If not, the CE must contact the EA. The kind of appointment (career, career-conditional, term or temporary) is shown on the SF-50, Notification of Personnel Action, or on Form PS-50 for Postal employees. The form should show clearly that the appointment is seasonal. An employee should not be considered career seasonal without explicit written documentation by the agency of his or her status.

(c) Employment during the year before the injury is not a factor. For example, compensation for a career seasonal firefighter paid at a GS-7 level, who had worked full-time in such a position by mutual agreement during more than one calendar year, would be computed at the full-time year-round GS-7 salary, regardless of how much or how little the employee worked during the year prior to the injury.

(d) An employee who has worked in a position with no prior written agreement is not considered to be a career seasonal employee. For example, a holiday casual Postal clerk may be rehired on new appointments several years in a row, but since the employer and the employee have not explicitly agreed that the employment will continue from year to year, it is not considered career seasonal work.

(2) Teachers. Teachers are not considered to fall under the provisions of career seasonal employment as set forth above in (1), but they are considered whole-year employment by nature of the position. As noted above, the FECA provides for different methods of computation of average annual earnings, depending on whether the employee worked in the employment in which he or she was injured for substantially a whole year. Substantially the whole year is normally defined as at least 11 months. However, in the teaching profession, substantially the whole year would not necessarily be 11 months. Therefore, in order to determine the average annual earnings for a teacher, consideration must be given to whether the claimant worked substantially the whole actual school year, i.e., 11/12ths of the school year, and whether he or she would have been employed for

substantially a whole school year had it not been for the injury.

(3) Concurrent employment. Concurrent employment can be included in determinations made under 5 U.S.C. 8114(d)(1) to the extent that it establishes the ability to work full time. As discussed more fully below, either similar or dissimilar employment can be used to demonstrate this ability.

Program Memorandum No. 147 discusses Irwin Goldman, 23 ECAB 6 (1971), and notes that a pay rate for compensation purposes is not limited to only what an employee earns in part-time employment for a Federal employer when there is concurrent employment that demonstrates the ability to work full time.

(a) When a claimant has been employed for 40 or more hours per week for substantially the year prior to injury, but not all of these hours are with a Federal employer, he or she has demonstrated the ability to work full time. Therefore, the claimant is entitled to compensation at the rate of a regular full-time employee in the same position.

(b) A claimant who can establish that he or she worked for substantially the entire year prior to the injury on a full-time basis is entitled to receive compensation on the same basis as a regular employee working in the same type of job. It does not matter what type of work the claimant performed during that year (though attending school is not considered employment and sporadic employment also would not demonstrate the ability to work full time). The fact that he or she had been employed consistently demonstrates the ability to work full time.

(c) Dissimilar employment. In the Goldman decision, it was determined that a part-time Postal employee who worked four hours per day, five days a week, and had a set salary, could have his pay rate expanded to support that his outside full-time employment in dissimilar private industry demonstrated he could perform work full-time as a Postal employee for compensation calculation purposes.

Therefore, work performed in another job during the year prior to a work-related injury can demonstrate an ability to perform full-time work in the job in which the injury occurred. When a part-time or short-term employee has demonstrated the ability to work full time by performing dissimilar employment for the year prior to the date of injury, the pay rate of an employee working full time in the actual Federal job held by the injured employee should be used to compute compensation.

However, the Goldman decision notes these same private industry earnings could not represent an employee's wage-earning capacity

(which is discussed in further detail in FECA PM 2-0814). The actual pay received for dissimilar employment cannot be used in the calculation of the pay rate, but the hours worked can be used to establish an employee's ability to work full time.

(d) Similar employment. Similar outside employment also demonstrates the ability to work full time; however, as opposed to dissimilar employment, similar employment requires the Office to combine the actual earnings from Federal employment with the actual earnings for the similar employment to obtain the average annual pay the employee earned. This total would be divided by 52 to obtain the weekly pay rate.

For example, if a part-time x-ray technician for the VA also works part-time as an x-ray technician at a private hospital, the total earnings of both would be added together to obtain the average annual earnings.

However, a pay rate based on full-time Federal employment may not generally be expanded to include the pay earned in any other concurrent employment, even if that employment is similar to the Federal duties. See J.G., Docket No. 05-943, issued May 23, 2007, where the injured worked was a full-time employee who worked another full-time job but was only entitled to compensation for wage loss for full-time Federal employment. Likewise, a pay rate based on career seasonal employment may not be expanded to include the pay earned "off season."

It is important to distinguish this situation from that addressed by the ECAB in Daniel Shaw, Docket No. 97-1680, issued April 14, 1999. In Shaw, the Board found that the transcript fees the employee, a court reporter, received constituted consideration for his federal employment and therefore were required to be included in the pay rate for compensation purposes. In this case, the claimant did not have similar, concurrent private-sector employment but, as an official court reporter, he was permitted by law to receive payment for transcripts he produced as part of his duties in addition to his salary. The fees he was allowed to charge for these transcripts were set by the employer. Payment was received from both the federal government and by private individuals for official, certified transcripts required in court proceedings. However, such payment was allowed by law and by the employing establishment, and the amount was set under the regulations of the employing establishment. Even though payment was received from other than the claimant's employer, the payment was made for the product of the duties he performed for his salaried position. He was, therefore, being paid for work performed within the performance of his duties.

(4) Pay for Whole Year Employment. For employees who have worked for at least a full year prior to the injury, but whose pay fluctuated during the year, the weekly pay rate for compensation purposes is determined under 5 U.S.C. 8114(d)(1)(B).

For instance, the pay rate of a rural carrier associate or part-time flexible employee of the Postal Service who works substantially the entire year prior to injury would be computed under section 8114(d)(1)(B), not section 8114(d)(3), even if the earnings fluctuated considerably from week to week, because an annual rate of pay can be established by obtaining the yearly earnings, without overtime, for the year prior to the injury.

b. Anticipated Whole-Year Employment – 5 U.S.C. 8114(d)(2).

5 U.S.C. 8114(d)(2) states,

(d) Average annual earnings are determined as follows:

(2) If the employee did not work in employment in which he was employed at the time of his injury during substantially the whole year immediately preceding the injury, but the position was one which would have afforded employment for substantially a whole year, the average annual earnings are a sum equal to the average annual earnings of an employee of the same class working substantially the whole immediately preceding year in the same or similar employment by the United States in the same or neighboring place, as determined under paragraph (1) of this subsection.

Therefore, the next issue to be considered in determining average annual earnings is anticipated whole-year employment. An affirmative answer to section 9(b) on Form CA-7 or item 20 on Form CA-6 is sufficient to show that the employee's position would have afforded employment for substantially a whole year had it not been for the injury. A negative, absent, or ambiguous answer to this question should prompt the CE to release Form CA-1030 to the EA. This can also be documented by a CA-110 following a call with the employing agency.

The average annual earnings are determined as described in paragraph 4(a) above. The discussion of concurrent employment in paragraph 4(a)(3) above also applies to these cases.

c. Irregular Employment – 5 U.S.C. 8114(d)(3).

5 U.S.C. 8114(d)(3) states,

(d) Average annual earnings are determined as follows:

(3) If either of the foregoing methods of determining the average annual earnings cannot be applied reasonably and fairly, the average annual earnings are a sum that reasonably represents the annual earning capacity of the injured employee in the employment in which he was working at the time

> of the injury having regard to the previous earnings of the employee in Federal employment, and of other employees of the United States in the same or most similar class working in the same or most similar employment in the same or neighboring location, other previous employment of the employee, or other relevant factors. However, the average annual earnings may not be less than 150 times the average daily wage the employee earned in the employment during the days employed within 1 year immediately preceding his injury.

Therefore, any situation not involving regular whole-year employment, career seasonal employment, a demonstrated ability to work full time, or anticipated whole-year employment – as discussed in the preceding paragraphs – is considered irregular employment. This category includes intermittent, seasonal, on-call, and discontinuous work, as well as employment where average annual earnings cannot be established under 5 U.S.C. 8114(d)(1) or (2).

The provisions of 5 U.S.C. 8114(d)(3) are not to be used if sections 8114(d)(1) or (2) can be applied. As noted earlier, for example, the pay rate of a part-time flexible employee of the Postal Service who works substantially the entire year prior to injury would be computed under section 8114(d)(1)(B), not section 8114(d)(3), even if the earnings fluctuated considerably from week to week, because an annual rate of pay can be established by obtaining the yearly earnings without overtime for the year prior to the injury.

Among other situations, irregular employment may include:

- Postal Service employees hired for the holiday season;
- Census enumerators (see paragraph 12 for further details);
- Casual firefighters hired by the Forest Service;
- Bin-site workers, county and precinct committee workers, and a variety of other inspection personnel, food technologists, veterinary medical officers, and agriculture commodity workers personnel employed on an occasional basis by the Department of Agriculture.

The Office must first take into consideration the earnings of the employee in Federal employment for the year prior to injury. Then the Office should review the earnings of other employees in the same or most similar class working in the same or most similar employment in the same or neighboring location. Finally, the Office must consider any other employment of the employee, or other relevant factors.

However, the average annual earnings may not be less than 150 times the average daily wage that the employee earned in the employment during the year just before the injury. This “150 Formula” should be used by the Office as a provisional pay rate when the employee is entitled to compensation for wage loss and further investigation is required to determine the claimant’s average annual earnings.

(1) Claimant's prior-year Federal employment. This information should be obtained from the EA or other Federal agency where the employee worked. Form CA-1030 may be used to request this information.

(2) Similarly-employed worker. The Office should determine the earnings of another Federal employee working the greatest number of hours during the year prior to the injury in the same or most similar class, in the same or neighboring locality, as obtained from the EA or another Federal agency in the same or neighboring locality. Form CA-1030 requests this information.

(a) "Same or most similar class" refers both to the kind of work performed and the kind of appointment held. A similarly situated employee would most likely hold the same type of appointment and the same pay grade and step as the claimant. For example, a rural carrier associate or part-time flexible employee should not be compared to a regular rural carrier or letter carrier, as these are different types of appointments. If the employee's job was temporary and seasonal in nature, it should be compared to that of another temporary and seasonal employee.

(b) If the "same or most similar class" contains more than one employee, the EA should be asked to state the earnings of the employee who worked the "greatest number of hours" and therefore had the highest earnings. If the claimant's term of employment is less than a year, the earnings of the similar employee should be pro-rated to match the same term of employment as the claimant's.

(c) The selected employee's grade and step should also be provided for reference so that it will be on file for wage-earning capacity purposes.

(3) Claimant's prior-year non-Federal employment. The CE will usually need to explore the claimant's full employment history for the year before the injury. This may be accomplished by sending Form CA-1029 to the employee, Form CA-1030 to the EA, or by other means, such as requesting pay stubs or tax returns, or holding a telephone conference with the claimant or EA. The CE may also release Form CA-935 with the SSA-581 to the claimant, and then send the claimant's completed SSA-581 to the Social Security Administration.

Form CA-1027 may be sent to private employers to verify the claimant's reported earnings, but if the earnings appear reasonable, they may be used without verification. Only earnings in employment which is the same as, or similar to, the work the employee was doing when injured may be considered. For this reason, the CE must determine the nature of the employment. Any other relevant factors which may pertain to the employee's "average annual earnings" in the employment in which he or she was working at the time of the injury should be considered. These factors are too various to enumerate,

so supportive rationale should be included in a pay rate memo.

(4) The "150 Formula." The last part of 5 U.S.C. 8114(d)(3) states that the average annual earnings **shall not be less than** 150 times the employee's average daily wage earned in the particular employment during the year just before the injury.

To obtain the average daily wage, the CE should divide the employee's gross earnings in the year prior to the injury by the actual number of days the employee worked. This figure is then multiplied by 150 and divided by 52.

However, in order to establish a provisional pay rate while obtaining other necessary information, the CE may calculate the daily wage on the actual date of injury and apply the 150 formula, i.e. hourly wage multiplied by the number of hours scheduled on the date of injury multiplied by 150 and divided by 52.

(5) To determine the employee's "average annual earnings" after development is complete, the CE should take the highest of:

(a) The earnings of the employee in the year prior to the injury, including any similar non-Federal employment;

(b) The earnings of a similarly-situated employee (see subparagraph (2) above); or

(c) The pay rate determined by the "150 formula."

(6) The CE should prepare a memorandum setting forth this determination and explaining the basis for it. This memorandum, which is subject to the certifier's concurrence, should be made part of the record. Unless conflicting evidence is present or a protest occurs, approval at a level higher than the certifier is not required.

(7) Absent evidence of varying pay rates, the CE need not investigate whether the pay rate changed during the year just before the injury. However, if such evidence is received, the CE should determine the employee's various pay rates during the year just before the injury and the number of days during such period the employee was paid at each rate. The average daily wage will be determined based on this evidence according to the number of days employed at each rate.

d. Employment without Pay –5 U.S.C. 8114(d)(4).

5 U.S.C. 8114(d)(4) states,

(d) Average annual earnings are determined as follows:

(4) If the employee served without pay or at nominal pay, paragraphs (1), (2), and (3) of this subsection apply as far as practicable, but the average annual earnings of the employee may not exceed the minimum rate of basic pay for GS-15. If the average annual earnings cannot be determined reasonably and fairly in the manner otherwise provided by this section, the average annual earnings shall be determined at the reasonable value of the services performed, but not in excess of $3,600 a year.

(1) Persons serving under 5 U.S.C. 8101(1)(B) – i.e., without pay or at nominal pay – come within the meaning of 5 U.S.C. 8114(d)(4). These persons usually have work schedules that are irregular as to hours worked per day and days worked per week, or the duration of the assignment is limited in some way.

The CE should consider these factors when determining a pay rate, using narrative letters or form letters CA-1027 or CA-1029 to request needed evidence. The CE should allow a pay rate based upon full-time employment only if the evidence clearly shows that the person had served on a full-time basis for substantially the whole year immediately preceding the injury, or that the assignment would have afforded employment for substantially the whole year.

(2) The EA should be asked to furnish the following evidence:

(a) A description of the duties performed by the claimant;

(b) Full details about the claimant's work schedule, including the hours worked per day, the days worked per week, the date when the claimant began the assignment, and the date when the assignment was to be completed; and

(c) The title, grade, and pay rate of a full-time position at the EA in which the service performed is the same or most similar to that performed by the injured person.

(3) The claimant should be asked to submit a signed statement showing all of his or her employment during the year immediately preceding the injury, including the names and addresses of employers, the type of work performed for each, and gross earnings exclusive of overtime from each employer.

(4) The CE should prepare a memorandum setting forth the pertinent facts and recommending a determination of the average annual earnings. The pay rate may not exceed the minimum rate of pay of an employee at the GS-15, step 10, level. A Senior CE or higher-level employee must concur with the determination.

2-0900-5 Effective Date of Pay Rate

2-0900-5. Effective Date of Pay Rate**.** This paragraph describes how to determine the date on which the pay rate should be based.

a. Disability Cases.

(1) In keeping with Section 5 U.S.C. 8101 (4), compensation in disability cases is computed using the pay rates in effect on:

(a) The date of injury (DOI);

(b) The date disability began (DDB); or

(c) The date disability recurred (DOR), if the recurrence began more than six months after the employee resumed regular full-time employment with the U.S.

The dates when compensable "disability began" or "disability recurred" are the dates the employee stopped work due to the injury, not the dates pay stopped. An increase of pay during the continuation of pay (COP) period does not change the pay rate for compensation purposes.

For occupational disease claims where the claimant remains exposed to the work factors claimed, the pay rate is the rate of pay effective the date of the last exposure to causal employment factors (which may be the date of a medical examination). If the claimant no longer remains exposed to the work factors claimed and there has been a change in work duties, e.g., limited duty, then the date of last exposure is used. See Patricia K. Cummings, 53 ECAB 623 (2002).

Peace Corps volunteers and VISTA and Job Corps enrollees are not covered by Section 5 U.S.C. 8101 (4); therefore, they are not entitled to a recurrent pay rate.

(2) The CE must first decide which date to use in establishing the pay rate for disability compensation. To do this, the CE should determine whether:

(a) The employee stopped work due to injury-related disability on or immediately after the date of injury; and

(b) The disability began at that time or is continuous from that time. If so, there is no choice and the DOI will be used.

(3) If the employee did not stop work on the DOI (or immediately afterward, defined as the next day), and the disability began at a later date, the case record should show the pay rate for the DOI and the DDB. The greater of the two will be used in computing compensation. If they are the same, the pay rate should be effective on the DDB. This is true even if the employee is working in private industry at the time the disability begins.

(4) Recurrences of disability are defined in FECA PM 2-1500 and 20 C.F.R. § 10.5(x). A recurrent pay rate applies only if the total or partial disability for work began more than six months after the first return to regular full-time employment (after the original disability)

with the U.S. To be eligible for a recurrent pay rate, there need not be a "continuous" six months of full-time employment prior to the recurrence of disability. See Johnny Muro, 19 ECAB 104 (1967).

(a) The ECAB has defined "regular" employment as "established and not fictitious, odd-lot or sheltered," contrasting it with a job created especially for a claimant. The ECAB has also noted that the duties of "regular" employment are covered by a specific job classification, pointing out that the legislative history of the 1960 amendments to the FECA, which added the alternative provisions to section 8101(4), demonstrates that "Congress was concerned with the cases in which the injured employee had 'recovered' or had 'apparently recovered' from the injury." The test is not whether the tasks that appellant performed during his limited duty would have been done by someone else, but instead whether he occupied a regular position that would have been performed by another employee. See also Eltore D. Chinchillo, 18 ECAB 647 (1967) [Remanding the case for further development, the ECAB noted that if the employee only returned to work in a temporary position designed to keep him on the payroll until his future ability to perform shipfitter duties was ascertained, the employee did not resume "regular" full-time employment within the meaning of the statute.]; and Thomas M. Schuerman, 51 ECAB 336 (2000) [Going to Vocational Rehabilitation isn't returning to regular full-time employment.].

(b) "Full time" means returning to the same number of hours of work per week as prior to the injury. For example, a claimant who worked a standard 40-hour week before the injury and returns to work eight hours per day for only three days per week has not returned to full-time employment. For employees who worked regular part-time schedules when injured, the term "full-time" should be construed as "full-schedule."

(c) Entitlement to a recurrent pay rate based on return to private employment requires that the employee must have returned to Federal employment after the original disability and six months must have elapsed since that return-to-work date. (See FECA Program Memoranda Nos. 164 and 268.)

(5) If a recurrence of disability is established, the CE should compare the pay rates on DOI, DDB, and DOR. The greatest of these pay rates will be used to compute compensation. Accepting a recurrence does not automatically constitute a recurrent pay rate. The employee still needs to meet the requirements of paragraph 5(a)(4) above.

(6) Once the claimant has met the initial requirements for entitlement to a recurrent pay rate, subsequent recurrences qualify the claimant for a new recurrent pay rate, without regard for another six-month return-to-work requirement. In determining subsequent DOR pay rates, however, the claimant's work schedule at the time of recurrence must be taken into account.

A recurrent pay rate may be lower than the pay rate in effect on the DOI, DDB, or previous DOR. This can happen when the claimant is originally injured in full-time employment, and the recurrence occurs when the claimant is working part-time or has been rated for loss of wage-earning capacity (LWEC). Even if the EA reports a higher hourly pay rate for a DOR, the recurrent pay rate should be considered the actual weekly amount the claimant earned. In such cases, the pay rate on DOI, DDB, or a previous DOR, with the applicable effective

date, would be used because it was higher.

(7) Due to application of cost-of-living increases, compensation based on the DOI pay rate may exceed the amount payable using the DOR pay rate. However, if the DOR pay rate is higher than the DOI pay rate, the DOR should be used, even if a lower payment of compensation will result. (See G.H., Docket 07-1738, 01/05/2009.)

(8) Payment of a schedule award does not entitle the claimant to a recurrent pay rate.

b. Non-Disability Cases.

(1) Claimants are entitled to receive compensation for medical appointments attended as a result of the injury. Medical appointments are not considered disability from work. Compensation for medical appointments should be computed on the pay rate in effect as of:

(a) The DOI, for traumatic injury claims;

(b) The date of last exposure (which is, in effect, the DOI), for occupational disease claims.

In an occupational disease claim, if the claimant continues to be exposed to the same work factors accepted as having caused the condition and claims compensation for medical appointments, the date of the first medical appointment is used as the DOI date, since that is the first date of any eligibility to compensation. Since the accepted period of exposure and/or work factors has already been determined, the effective pay rate date will not change unless the employee actually becomes disabled (e.g., surgery, lack of suitable work, etc.) or later files a claim for a schedule award (in which case the actual date of last exposure should be used as the DOI pay rate).

If the claimant did not lose any time from work but began working limited or modified duties due to restrictions imposed as a result of the accepted injury, then the date prior to the date the modified duty began should be used as a new DOI pay rate and pay rate effective date for purposes of paying compensation for ongoing medical appointments, since this is the date of last exposure to the work factors that were accepted by OWCP.

If the claimant then loses time from work due to disability resulting from the work injury, a new pay rate (DDB) would be established.

c. Schedule Award Cases. The pay rate used for the payment of the schedule award is the greatest of the established pay rates (DOI, DDB, or DOR). See Exhibit 1.

For occupational disease claims where the claimant remains exposed to the work factors claimed, the pay rate is the rate of pay effective the date of the medical examination. If the claimant no longer remains exposed to the work factors claimed and there has been a change in work duties, e.g., limited duty, then the date of last exposure is used. See Patricia K. Cummings, 53 ECAB 623 (2002).

Where there was no prior injury-related disability from work, the DOI pay rate should be

used. However, the CPI-effective date is the beginning date of the schedule award, since that is the first date of any eligibility to compensation.

d. Death Cases. The pay rate in death cases is determined by the DOI, which is the date of death, unless a different pay rate has been reached in a disability claim due to delayed or recurrent disability leading to the death, or because the decedent was a minor or learner whose pay rate was re-determined according to 5 U.S.C. 8113(a). (See paragraph 12a below.)

2-0900-6 Elements Included from Pay Rate

6. Elements Included from Pay Rate. This paragraph lists the increments of pay which may be included in the pay rate, either by statute or administrative determination.

a. Statutory Inclusions.

(1) 5 U.S.C. 8114 includes the following elements for determining an employee's pay rate:

(a) The employee's full salary or full cash wage;

(b) The value of any subsistence and quarters received for services in addition to the cash wage (not including subsistence and quarters furnished by the employer and paid for directly by the employee or by deduction from the employee's salary); and

(c) Premium pay for scheduled standby duty as provided by 5 U.S.C. 5545(c)(1).

(2) The employer does not usually provide subsistence and quarters to employees unless the conditions and place of employment render it impossible or impractical for an employee to obtain food and lodging from another source. Therefore, the CE need be concerned with subsistence and quarters only where:

(a) The industry or the employer customarily provides such services (e.g., crew members employed by the Military Sealift Command, employees aboard boats, dredges, barges, and floating plant vessels, or temporary firefighters working for the Forest Service);

(b) A quarters allowance is paid to personnel serving overseas, pursuant to Section 901(1) of the Foreign Service Act of 1946 and Executive Order No. 10011, dated October 22, 1948; or

(c) Item 18 on Form CA-6, section 8 on Form CA-7, or some other written evidence from the claimant or employing agency shows that the employer provided food and lodging.

b. Administrative Inclusions. It has been determined administratively that the following elements will be included in computing an employee's pay rate:

(1) Night differential is paid for regularly scheduled work between the hours of 6:00 p.m. and 6:00 a.m.

(2) Shift differential is paid to wage-grade employees and is typically 7.5% for the entire shift of a swing shift or shift 2. This differs from night differential in that shift differential is typically paid for the entire shift if the majority of that shift falls after or before the hours of 6:00 p.m.

(3) Extra compensation for performing work on Sundays or holidays paid to regular employees of the Postal Service.

(4) Premium pay for work on Sundays and/or Saturdays under 5 U.S.C. 5546(a), which provides for extra pay when an employee's regular work schedule includes an eight-hour period, any part of which falls on a Sunday or described as being within the period commencing at 12:00 a.m. Saturday and ending at 12:00 a.m. Sunday. Saturday pay is usually payable to health professionals working for the Department of Veterans' Affairs.

(5) Premium pay for work on holidays under 5 U.S.C. 5546(b), which provides for extra pay when an employee's regular schedule includes work on a holiday. This increment may not be paid for work which exceeds eight hours or which represents overtime.

(6) Retention pay when the employee is in a field which is difficult to staff or requires specific and/or difficult to hire employment, such as certain medical professionals, Military Sealift Command employees, or air traffic controllers. This will be documented by the agency if this is included and provided by the agency.

(7) Premium pay for administratively uncontrollable overtime (AUO), including holiday pay under 5 U.S.C. 5545(c)(2) (see also FECA Program Memoranda Nos. 106 and 280).

(8) Availability pay for criminal investigators pursuant to 5 U.S.C. 5545a. This increment (25% of basic pay) is paid to ensure the availability of investigators for unscheduled duty, and replaces AUO (see above) for these employees.

(9) Extra pay received by immigration inspectors for work performed between 5:00 p.m. and 8:00 a.m., and for all work performed on Sundays and holidays (see FECA Program Memorandum No. 68).

(10) Extra pay received by customs inspectors for work performed between 5:00 p.m. and 8:00 a.m., and for all work performed on Sundays and

holidays, until January 1, 1994 (see FECA Program Memoranda Nos. 278 and 281).

(11) Wages paid for National Guard service when membership in the National Guard is a condition of the employee's civilian employment with the Guard.

Earnings received for active Federal service under a Presidential call are also included. A Presidential call is a statutory method by which reservists can be involuntarily ordered to active duty. Any extra wages earned for this specific service under a Presidential call should be obtained for the year prior to the date of injury, since serving under a Presidential call is not a voluntary action. This should be divided by 52 weeks and added to the basic pay rate. Other supplemental Reserve pay, obtained through voluntary actions of the employee, is not included. (See R.E., ECAB Docket 2008-1728, issued April 10, 2009.) [Any compensation that was paid for other voluntary active duty pay prior to the issuance of this ECAB decision is not considered an overpayment of compensation.]

(12) Extra pay authorized under the Fair Labor Standards Act (FLSA), 29 U.S.C. 207(k), for emergency medical technicians and other employees who earn and use leave on the basis of their entire tour of duty, and who are required to work more than 106 hours per pay period. GS-081 firefighters with pay-rate effective dates prior to October 11, 1998 would also be included in this section.

Such pay may be included retroactive to July 21, 1987, when OPM made changes in its regulations. To be entitled to an adjustment in the pay rate, the claimant must have been in pay status on or after that date. If retroactive payment is authorized in a long-term disability case, the pay rate must be adjusted so that CPIs will be included.

(13) The Federal Firefighters Overtime Pay Reform Act of 1998 (Public Law No. 105-277) amended Title 5 of the U.S. Code to define hours worked by firefighters in excess of 106 bi-weekly, or 53 weekly, as "overtime." Public Law 106-554, which was enacted in December 2000, contained language establishing that those hours in excess of 106 bi-weekly (or 53 weekly) should not be considered "overtime" pay for the purpose of computing pay under Section 5 U.S.C. 5545b. These changes became effective the first day of the first pay period after October 1, 1998. (This date is presumed to be October 11, 1998.) This change applies only to GS-081 firefighters who are covered by Section 5 U.S.C. 5545b.

The Federal Firefighters Overtime Pay Reform Act of 1998 provides "overtime" for hours in the regular tour of duty to both FLSA nonexempt and exempt firefighters. The weekly pay rates are computed in the same manner for both types of firefighters, except there is a cap on the "overtime" hourly rates for FLSA exempt firefighters. The cap is set at 1.5 times the GS-10, step 1

hourly rate (computed using the 2087 divisor and including any applicable locality pay), but the capped rate may not fall below the individual firefighter's hourly rate of basic pay.

(14) Premium, hazard and penalty pay for crew members employed by the Military Sealift Command is granted by the master of the ship they work for and is only paid depending on the needs of this ship and its particular mission. Not all crew members may earn these pay elements, but these are payments for involuntary duties.

The following are considered "leave supplements" that are paid to all unlicensed crew members or watch-standing officers by the Military Sealift Command, to compensate for overtime, penalty or premium pay that is not earned while on authorized leave. The leave supplement is a means of maintaining wage differentials among the crew, and is not among the categories of pay excluded by Section 5 U.S.C. 8114(e).

(a) Hazard pay. This is only earned when the boat is in a combat zone during wartime. When the ship is not in a combat zone, this cannot be earned by any crew member.

(b) Premium pay. This is dependent on the position and duties of the crew member and granted by the master of the ship itself when a crew member is ordered to do specific tasks that will require a minimum of two hours to perform.

(c) Penalty pay. This is paid when a specific task requires a crew member to miss meals or sleep (such as a task which is required at night).

(d) Subsistence pay. This is paid when a crew member lives over 50 miles from his or her regular duty station and is waiting for work and in an official standby waiting status; this will be granted by the master of the boat.

(e) Habitability pay. This is paid when crew members are required to stay on shore while their assigned boat is being serviced in dry dock.

(f) Retention Allowance. This is paid as an incentive to retain personnel such as able seamen or engineers.

(g) "Non-watch" or Non-watch-standing pay. This is paid to able seamen or engine personnel who are performing security duties for a particular boat. These are the only two types of employees who may earn this pay as part of their assigned duties.

The extra pay the claimant earned for these items in the year prior to the

effective pay rate date should be requested from Military Sealift Command payroll or injury compensation staff, since the amount earned can vary widely.

(15) FAA Air Traffic Controller (ATC) Pay. Along with night differential, Sunday premium, or holiday pay, an ATC can earn the following extra pay, as it is involuntarily earned based upon the employer's needs: Controller-in-Charge and controller retention or incentive pay.

(16) "Arctic bonus" pay received by personnel working at Foreign Arctic Weather Stations of the National Oceanic and Atmospheric Administration, Department of Commerce.

(17) "Dirty-work pay" extended to employees who work under conditions which soil the body or clothing more than normally expected in performing the duties of the job.

(18) "Hazard pay" when it is included for work which is recurrent in nature and part of the employee's normal duties. This is not to be confused with "danger pay" awarded for hazardous services in time of war, which is excluded as described in the next section.

(19) Locality pay or "COLA" (cost-of-living allowance) paid to certain employees as part of their normal pay and in addition to their salary, because of differences in cost of living within the U.S. and its possessions (e.g., Puerto Rico).

(20) "Remote worksite allowance" under the provisions of 5 U.S.C. 5942 paid to certain employees assigned to regular duty at designated locations so remote from the nearest established communities or suitable places of residence as to require an appreciable degree of expense, hardship, and inconvenience beyond that normally encountered in metropolitan commuting.

(21) "Post differential" paid under 5 U.S.C. 5925. This is regarded as a special recruitment and retention allowance granted because of the overall environmental conditions or rigors of the particular post. It is not a cost-of-living differential or economic equalization factor, which would be excluded from the pay rate for compensation purposes.

(22) Dive pay is authorized for wage system employees for those hours when they are actually performing diving duties. The pay rate is 175 percent of the WG-10, step 2 rate, adjusted for locality.

2-0900-7 Elements Excluded in Pay Rate

7. Elements Excluded in Pay Rate. This paragraph list the increments of pay which may not be included in the pay rate, as determined either by statute or administrative decision.

a. Statutory Exclusions. 5 U.S.C. 8114(e) excludes the following elements from

an employee's pay rate:

(1) Overtime pay. The extra pay required by the Fair Labor Standards Act (FLSA) for hours worked in excess of the standard prescribed under the FLSA is not to be included in computing pay for the purposes of continuation of pay or compensation. Such extra pay is earned only if the actual hours are worked and is considered to be overtime pay for the purposes of 5 U.S.C. 8114(e).

(2) Additional pay or post-allowance authorized outside the United States and its possessions because of differential in cost of living or other special circumstances. The separate maintenance allowance authorized in 5 U.S.C. 5923(3) is also excluded, since it is a cost-of-living allowance paid to an employee in a foreign area.

(3) Bonus or premium pay for extraordinary service, including "danger pay," which is any amount paid as a bonus for particularly hazardous services in time of war.

b. Administrative Exclusions.

(1) Per diem received by an employee while in a travel status.

(2) Extra allowance paid for an employee's use of his or her private motor vehicle (such as rural carriers for the US Postal Service).

(3) Unemployment compensation.

(4) Earnings from dissimilar concurrent employment. For example, if the claimant works for the Federal Government as a part-time secretary and also works as a cashier part time for a private employer, the earnings from the cashier position would not be included in the pay rate. However, such earnings may help in determining the claimant's ability to work full time. (See section 4(a)(3) above.)

(5) Earnings as an activated reservist or National Guard member when the activation is not as a result of a presidential call under §12301(a), §12302, or §12304 of Title 10, United States Code (See R.E.. Docket 08-1728, 04/10/2009.)

(6) Earnings as a reservist or National Guard member when the membership is not a condition of the employee's civilian employment with the Guard or Reserve.

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 be obtained in

writing or by a phone call to the EA and then documented by placing a CA-110 in file.

a. Receipt on Regular Basis. If an additional amount or percentage was paid for premium, night differential, holiday, shift pay, FLSA extra pay, or firefighters extra pay (see paragraph 6 in this chapter), and the file contains no evidence showing that this amount varies or is paid irregularly, the CE may add the indicated amount or percentage to the base pay reported without further inquiry. The CE should verify with the employing agency whether shift differential is included with the base pay provided for wage-grade employees.

Sunday premium pay, however, is an exception and should be requested for the year prior to the pay rate effective date, even if the claimant is scheduled to work every Sunday. Sunday premium pay is only paid for actual time worked. It is not paid for periods of leave taken.

b. Varying Amounts. If the evidence shows that the amount or percentage paid for premium, night differential, shift pay, FLSA extra pay, or firefighters extra pay varies or is paid irregularly, the CE should determine the amount of additional pay received during that year and add it to the reported base pay. (See subparagraph 8(c) below concerning FLSA pay and subparagraph 8(d) below concerning firefighters' pay.)

c. FLSA Pay for Firefighters. The pay rates of individuals entitled to this increment of pay are based on annual pay rate and percentage of premium pay. Their pay is based on 144 hours of work each 14-day pay period, of which 106 are regular hours and 38 are FLSA overtime hours. The number of biweekly hours should be verified with the employing agency if not readily determined in the case documentation. The formula is as follows:

(1) Yearly pay/26 = basic biweekly pay.

(2) Basic biweekly pay x premium pay percentage = standby premium pay.

(3) Basic biweekly pay + standby premium pay = total pay without FLSA Overtime.

(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 = biweekly 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 = biweekly "firefighter overtime."

(e) (Biweekly base pay + biweekly "firefighter overtime") / 2 = weekly pay rate.

(Note: most 24-hour shift firefighters have a regular biweekly tour of 144 hours (six 24-hours shifts), consisting of 106 regular hours and 38 "firefighter overtime" hours; thus, 38 hours (144-106) would be used in step (d) above.)

(2) Firefighters with an extended regular tour built on top of a 40-hour basic workweek.

(a) (Annual salary / 2087) X 80 hours = biweekly base pay.

(b) Annual salary/ 2756 = firefighter hourly rate.

(c) Firefighter hourly rate X 26 hours = additional biweekly base pay.

(d) Firefighter hourly rate X 1.5 = "firefighter overtime" rate (subject to GS-10, step 1 cap as described in PM 2-0900.7.b.(22).

(e) "Firefighter overtime" rate X hours in regular tour in excess of 106 hours = biweekly "firefighter overtime".

(f) (Biweekly base pay + additional biweekly base pay + biweekly "firefighter overtime") / 2 = weekly pay rate.

(Note: a common schedule would be a 40+16 weekly tour, which translates into a biweekly tour of 112 hours, including 6 "firefighter overtime" hours to be used in step (e) above.)

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 all of the following four tests are met:

(1) The injury caused only temporary total disability.

(2) The period of compensable disability (the period for which compensation is paid) does not, or is not expected to, exceed 90 calendar days.

(3) No additional increments of pay (e.g. Sunday premium, shift differential, etc.) are involved.

(4) The "average annual earnings" of the employee are not readily determinable.

b. Length and Permanency of Disability. In deciding whether the injury will likely cause permanent disability or a period of temporary total disability exceeding 90 calendar days, the CE must consider the nature and severity of the injury; the medical prognosis; the age of the employee; and the nature of the employment. When it is unclear whether permanent effects will result from the injury, or whether the temporary total disability will exceed 90 calendar days, and the "average annual earnings" cannot be readily determined, the CE should set up payment based on the daily pay rate and make appropriate inquiries to develop the weekly pay rate.

If the disability extends beyond 90 calendar days, the CE will need to reassess the pay rate.

c. Fixed Schedule. Where the evidence on Form CA-1 or CA-2 shows that the employee works the same hours on a daily basis and the same days each week, the CE will determine the actual daily wage according to how it is reported:

(1) If the wage reported is on a daily basis, the amount shown will be used as the actual daily wage;

(2) If the wage reported is on an hourly basis, the actual daily wage will be computed by multiplying the hourly pay by the hours worked per day shown in item 20 on Form CA-1 or item 21 on Form CA-2; or

d. Intermittent Schedule. Where Form CA-1 or CA-2 shows that the employee did not work the same hours per day or the same days per week, the CE should obtain the actual dates worked during the month immediately preceding the injury to determine whether the employee worked a reasonably regular schedule of 5, 5 ½, or

6 days per week, for example. This is necessary to determine the actual days of compensation entitlement.

If the claimant worked a reasonably regular schedule, the actual daily wage will be computed by dividing the employee's gross earnings during the month just before the injury by the actual number of days the employee worked during such period.

e. If paying compensation on a daily rate, the employee is paid for the days he or she would have worked but for the injury (work days). For example, a married worker sustains an ankle fracture on her third day of employment and stops work. She is disabled for 17 days before returning to her full, regular duties. The employee was hired on a temporary basis and makes $10.00 per hour. The EA reports that the claimant worked 15 total hours during her 3 days of employment. The daily pay rate would be calculated as follows:

15 hours divided by 3 days = 5 hours per day
$10.00 per hr X 5 hrs per day = $50.00
$50.00 X ¾ = $37.50 per day compensation rate
$37.50 x 17 days lost = $637.50

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 workweek, 5½ for a five-and-a-half day workweek, and so on.

c. Hourly Basis.

(1) For Postal Service employees, the amount shown is multiplied by 2080, and then divided by 52.

For USPS employees who work less than a full schedule, the figure of 2080 hours should be prorated (e.g. 1040 hours when the employee works four hours per day), then multiplied by the amount shown; or

(2) For regular Federal employees, the amount shown is multiplied by 2087 (by administrative determination, the number of hours in a full work year based on a 40-hour work week). This figure is then divided by 52.

For employees who work less than a full schedule, the figure of 2087 hours should be prorated (e.g., to 1043.5 hours when the employee works four hours per day), then multiplied by the amount shown.

The figure of 2087 hours equals 52 weeks plus .875 of one workday. To

calculate increments of pay (night, Sunday, etc.), first multiply the hourly increment by 2087, then divide the sum by 52 to obtain the amount of the weekly increment.

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. For example, if the average annual earnings are determined to be $65,000, the claimant's monthly pay rate would be established as $5,416.67 ($65,000/12).

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/Learner's Capacity. 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. David J. McDonald, 50 ECAB 185, Docket No. 96-1144; December 10, 1998 (Appellant not entitled to a learner's capacity) contains a good discussion of this topic.

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.) 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. See 5 U.S.C. 8142.

(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. See 5 U.S.C. 8143.

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 — 2010 Census. (For injuries occurring during previous censuses, consult the National Office.) Information about calculating compensation for these employees may be found in FECA PM 2-0901.

(1) For the 2010 census, the Bureau of the Census hired individuals in Local Census Offices (LCOs) throughout the U.S., including Alaska, Hawaii and Puerto Rico. Most employees in LCOs were either enumerators or crew leaders on temporary (not-to-exceed 180 days) appointments.

(2) All temporary-hire positions, including enumerators and crew leaders, were paid on an hourly basis. Wages in the LCOs varied by geographical area, and pay types were assigned accordingly. Any questions regarding pay rates can be referred to the Bureau of the Census, Demographic and Decennial Staff, at (301) 763-9620. Following are the hourly wage rates for enumerators, crew leaders and clerks:

Enumerator:	$10.93 to $22.10
Crew Leader:	$12.43 to $23.60
Clerk:	$ 8.20 to $15.82

(3) Based on an analysis of the 2000 Census data, the Bureau of the Census determined that, on average, enumerators worked 4.5 hours per day, 4 days per week. The work patterns for the 2010 Census were anticipated to be similar to the 2000 Census. However, individuals may have worked more or less depending on the LCO's operational requirements, and the factual evidence should be evaluated carefully. Because of their irregular Federal employment, these employees are usually paid under the provisions of 5 U.S.C. 8114(d)(3), as outlined in 4(c) of this chapter.

(4) Temporary hire workers may have worked more than one "operation" or assignment during the course of their employment for the census. The CE should evaluate the particular duty requirements for each position when determining whether any collateral or consecutive jobs constitute "same or

similar employment" under §8114 of the Act when calculating compensation.

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. As they are covered under separate legislation, it has been determined that they are not eligible for COP (Reference 20 CFR §10.200). The CE should follow the guidance given above in paragraph 4 to establish their average annual earnings.

g. Performance-Based Alternative Pay Systems (Pay Banding). Some Federal agencies have adopted the use of performance-based alternative pay systems. There are numerous performance-based pay systems, but they all link individual base pay and bonuses to performance. Most options do not provide for any automatic pay increases. These pay systems give managers more flexibility in setting the pay for new employees (as well as current employees).

In performance-based pay systems (also known as pay banding), agencies may collapse the 15 General Schedule grades into a smaller number of pay ranges. For example, the GS grades could be collapsed into four bands which cover GS-1 through 5, GS-6 through 11, GS-12 through 13, and GS-14 through 15. Once the bands are defined, the agency may hire an employee at any pay amount within a band and determine how employees move within and across bands.

(h) Reemployed annuitants. The pay rate should be based on the salary of a full-time Federal worker. Section 8114(d)(3) of the Act provides that the pay rate used should reasonably represent the pay rate of the employee in the Federal job when injured and of other Federal employees in the same or similar class. However, if a claimant has private sector earnings which are similar to the part-time Federal job duties, the employee's pay rate must be established under Section 8114(d)(3). Note: If a reemployed annuitant officially retired prior to the stated injury, he or she must make an election between FECA benefits and OPM (see FECA PM 2-1000).

2-0900 Exhibit 1

Exhibit 1 - DETERMINING EFFECTIVE PAY RATE DATE FOR SCHEDULE AWARDS

Traumatic Injury Claims –

With prior disability:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
SA Start Date = DMI (date of maximum medical improvement)
CPI Start Date = DOI, DDB, or DOR (pay rate effective date)

Without prior disability:

Pay Rate Date = DOI
SA Start Date = DMI
CPI Start Date = DMI

Occupational Disease Claims –

With prior disability, working full duty (still exposed to injurious work factors) at time of rating exam:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
(DOI = Date of Last Exposure (DLE) = Date of Impairment rating exam)
SA Start Date = DMI
CPI Start Date = DOI, DDB or DOR (pay rate effective date)

With prior disability, not working or working limited duty at time of rating exam:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
SA Start Date = DMI
CPI Start Date = DOI, DDB or DOR (pay rate effective date)

Without prior disability:

Pay Rate Date = DOI
(DOI = DLE = Last date exposed to causal employment factors in full-duty capacity or date of medical exam if still exposed)
SA Start Date = DMI
CPI Start Date = DMI

Occupational Hearing Loss and Asbestosis Claims –

When claimant is disabled due to occupational hearing loss or asbestosis:

Pay Rate Date = DOI, DDB, or DOR (whichever is greatest)
SA Start Date = DMI
CPI Start Date = DOI, DDB or DOR (pay rate effective date)

When there is no disability, claimant has continuing exposure:

Pay Rate Date = DOI
(DOI = DLE = date of last exposure before diagnostic exam – audiogram/chest x-ray)
SA Start Date = DMI
CPI Start Date = DMI = date of audiogram or chest x-ray

When there is no disability, retired:

Pay Rate Date = DOI
(DOI = date of retirement or last documented date of exposure to hazardous noise or asbestos)
SA Start Date = DMI
CPI Start Date = DMI = date of last audiogram or chest x-ray

* The SA start date can be moved forward in time if documented in the case file. However, it cannot be moved back in time. See PM 2-808-7.

2-0901 COMPUTING COMPENSATION

TABLE OF CONTENTS

Exhibits

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 2-0900.12.

(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 4.5 hours per day, 4 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 4.5 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 medical improvement unless circumstances show a later date should be used. See Mark A. Holloway, 55 ECAB 321 (2004) ("The determination of whether maximum medical improvement has been reached is based on the probative medical evidence of record, and is usually considered to be the date of the evaluation by the attending physician which is accepted as definitive by the [OWCP]."). See also Marie J. Born, 28 ECAB 89, 93 (1976) (a retroactive determination of the date of maximum improvement is not *per se* erroneous. When the medical evidence establishes that the employee did in fact reach maximum improvement by such date, the determination is proper, assuming that it is made within a reasonable time after the date of maximum improvement).

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, the Compensation System will compute the ending date of an award and terminate payments accordingly. The Claims Examiner should use the certified payment sheet in the file to obtain the information to complete Form CA-181, Schedule Award Decision.

d. Fraction of Day (FOD). Where the award ends in a fraction of a day, line 3 of Form CA-181, Schedule Award Decision, should include the phrase "fraction of a day."

For example: An award for 15 percent loss of use of a foot is 30.75 weeks of compensation. The two-place decimal is retained, and the partial day it represents is called "fraction of a day," or FOD. The dates of payment might be shown as, "March 2, 2004 to October 4, 2004, 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 LWEC. 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 2-0814.)

(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 15c below.

b. Shadrick Formula. The method for computing the compensation payable where an employee has actual earnings or a wage-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. 8106(a) 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:

> Although capacity to earn and not wages received is the proper test under the law, an employee's actual wages may constitute compelling evidence of his capacity to earn and in a proper case may be used as a yardstick in determining an injured employee's diminished earning capacity.

However, in applying this standard, the ECAB held:

...wages received 2, 5 or 10 years after an employee has sustained an injury and during which period changes in business conditions have caused wages to double due to a business boom or to be cut in half due to a depression cannot be used as a conclusive factor in determining a claimant's diminished wage-earning capacity after he has been injured.

The ECAB concluded, "Actual dollar earnings received several years after injury may be used to determine wage-earning capacity only after they have been converted into terms of actual dollar earnings received at the time of injury."

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 same date used for the comparison.

In calculating LWEC, the direct comparison of wages in lines 2 and 3 of the formula above is always based on the current salary of the job when injured, not that held at the time disability began or the date disability recurred.

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 15c 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 provided by 5 U.S.C. 8146 and 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 have 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.

(3) Performance-Based Alternative Pay Systems (Pay Banding).

Some agencies have adopted performance-based pay systems (also known as pay banding), which link individual base pay and bonuses to performance. Instead of a set of distinct grades and steps, broad pay bands are used, and managers have more flexibility in setting the pay for new and current employees. Most options do not provide for any automatic pay increases. For example, the 15 General Schedule grades could be collapsed into four bands which cover GS-1 through 5, GS-6 through 11, GS-12 through 13 and GS-14 through 15. Once the bands are defined, an agency may hire an employee at any pay amount within a band and determine how employees move within and across bands.

In calculating LWEC, if the date of injury (DOI) position was paid based on a specific grade and step, the CE simply needs to determine the current pay rate for the DOI position. However, as a result of the fluidity of pay rates within pay bands, there may not be a definitive grade and step for the DOI pay rate. When calculating a loss of wage-earning capacity in cases where a specific grade and step were not assigned to the DOI position, the CE will first need to determine the injured employee's DOI pay rate as a percentage of the appropriate band.

Once that percentage has been established, the current pay rate for the DOI job (as entered in the Shadrick formula) will be the same percentage of the current pay range for the band in which the employee was being paid on the

DOI. For example, if the employee was hired in the second band (with a range of $28,085 through $60,049) at a salary of $50,000, then he or she earns 69% of the total range. If the current range of the band in which he or she was being paid on the DOI is $35,000 through $72,000, then $60,530 will be the current salary since it is 69% of the new range. When calculating the percentage of the pay band range, normal rounding rules apply.

The steps for determining the percentage of the band on the DOI are as follows:

1) Determine the range of the DOI pay band by deducting the lowest salary from the highest salary within that band. (In the example above, $60,049 – $28,085 = $31,964)

2) Deduct the salary at the low end of the band from the actual salary paid to the claimant. ($50,000 – $28,085 = $21,915)

3) Take the amount from step 2 and divide it by the amount from step 1. This will give the percentage of the salary range that the claimant earned on the date of injury. ($21,915 divided by $31,964 = 69%). The CE must document the case record with the calculation worksheet.

The steps for determining the current salary for the DOI job are as follows:

1) Determine the range of the current salaries for the DOI pay band by deducting the lowest salary from the highest salary within that band. (In the example given, $72,000 – $35,000 = $37,000)

2) Multiply the amount from step 1 by the percentage of the band that the employee was earning at the date of injury. ($37,000 x 69% = $25,530)

3) Add the number obtained in the second step to the lowest salary in the current range for the appropriate band. This will give you the current pay rate for the job held when injured. ($25,530 + $35,000 = $60,530.).

Once the current pay rate for the job held when injured is calculated according to the above instructions, it can be entered into the Shadrick formula so that compensation for LWEC can be paid to the claimant. The CE must document the case record with the CA-816 form or equivalent.

g. Reinjury. When a reemployed claimant who has been rated for LWEC sustains a new injury, which is not merely a change in the nature and extent of the injury-related condition (one of the three criteria for modifying an LWEC), 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 at the time of the second injury should be used to compute compensation for disability resulting from that injury. If the employee was only working on a part-time basis at the time of the second injury, the part-time salary should form the basis of the calculation of the pay rate for the job held at the time of the second injury. (In other words, a full-time salary should not be used as the pay rate for the second injury if the employee was only working part-time.)

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 William A. Archer, 55 ECAB 674 (2004) ("For a routine medical appointment, [OWCP] guidelines indicate that a maximum of four hours of compensation is usually allowed."). See also Dorothy J. Bell, 47 ECAB 624 (1996) (OWCP's obligation to pay for medical expenses, and expenses incidental to obtaining medical care, such as loss of wages, extends only to expenses incurred for treatment of the effects of an employment-related condition. To be entitled to compensation for time missed from work due to medical treatment for an employment-related condition, appellant must meet his or her burden of proof to establish that a loss of wages incurred to obtain medical treatment was related to an accepted condition).

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. See also Amelia S. Jefferson, 57 ECAB 183 (2005) (ECAB stated that the absence from work for the purpose of medical evaluation does not constitute a recurrence of disability and such absence from work will not entitle the claimant to a higher pay rate under section 8101(4) of the FECA).

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 payable under 5 U.S.C. 8133 and 8134 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.

a. Funeral and Burial Expenses. The FECA provides up to $800 for funeral and burial expenses. 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.

c. Transportation Expenses. The CE should briefly describe the nature and amount of this payment on the payment sheet.

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. 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 failing to comply with or 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. OWCP has also entered into a Memorandum of Understanding with the Department of Health and Human Services Office of Child Support Enforcement in order to identify parents who owe child support. In such cases, state agencies may issue Income Withholding Orders for back child support.

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. 20 C.F.R. § 10.424. The representative payee is not equivalent to an authorized representative which may be designated by a claimant to represent him before proceedings before the OWCP, pursuant to 5 U.S.C. 8127 and Procedure Manual, Chapter 2-1200.

(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 (20 C.F.R. § 10.425). See Aberline Smith, Docket No. 96-1699 (issued June 4, 1998) (FECA does not govern whether a claimant may or may not buy back leave from an employing establishment, and any decision by the employing establishment to disallow leave buy back is not a decision of the OWCP over which the ECAB may exercise jurisdiction). 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. Upon receipt of the agency certified LBB claim, (CA-7, 7a, 7b), the claim will be keyed into the compensation management system. 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). The CE should then 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. 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-1208 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 develop 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 will 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 develop 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.

2-0901-20 Dependents

20. 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 or a child incapable of self-support, the CE must ensure that entitlement exists.

a. Student Status. Augmented compensation paid based on an unmarried child, which would otherwise be terminated when the child turns 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 child reaches age 23, whichever comes first.

(1) A "year of education beyond the high school level" is defined as:

i. 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.

ii. 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.

(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)(ii) above. In this situation, the claimant would remain entitled to four years of augmented compensation based on school attendance, provided the child does not turn 23.

In either case, augmented compensation is continued during any interval between school terms which does not exceed four months if the child demonstrates a bona fide intent to continue in school the following year. In the absence of specific contrary evidence, the CE may consider the student's decision to begin or continue full-time studies a bona fide statement of intent.

(4) Where a student is prevented by reasons beyond his or her control (such as brief but incapacitating illness) from continuing in school, augmented compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The CE will determine what constitutes "reasons beyond the control" of the child and decide what may be considered a period of reasonable duration during which augmented compensation may be continued. The CE should 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 2-812.8b concerning release of Form CA-1615. If the claimant is still receiving augmented compensation when the child turns 23, compensation should terminate at the end of that semester or enrollment period.

b. Marriage of Child. Eligibility based on a dependent child terminates on the date of the child's marriage.

c. Children Over 18 Who are Incapable of Self-Support. When augmented compensation is claimed based on a child over 18 who is physically or mentally incapable of self-support, the CE must investigate the extent and expected duration of the illness involved.

(1) Eligibility. The child over 18 must be incapable of self-support by reason of a mental or physical disability at the time the claimant became eligible for disability benefits. Augmented compensation is not payable for a child over 18 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 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.

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 @ ¾	WEEK @2/3 / WEEK @3/4	DISABLITY MIN COMP RATES[2] PER DAY/WEK	(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	70.63-105.95	14.13	70.63-(282.52)	408.08
		14.13-18.84	70.63- 94.17			
03/01/71	4.0					
01/09/72		14.90-22.35	74.51-111.77	14.90	74.51-(298.04)	430.50
		14.90-19.87	74.51- 99.35			

[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

		SALARY RANGE [1] PER		DISABLITY MIN COMP RATES[2] PER		DEATH MIN PAY RATES[3]
EFFECTIVE DATE	CPI	Day @ 2/3	WEEK @2/3			
	(%)	Day @ 3/4	WEEK @3/4	DAY/WEEK	(4 WEEK)	PER MONTH
05/01/72	3.9					
10/01/72		15.67-23.50	78.35-117.52	15.67	78.35-(313.40)	452.60
		15.67-20.89	78.35-104.46			
06/01/73	4.8					
10/14/73		16.39-24.58	81.95-122.93	16.39	81.95-(327.80)	473.50
		16.39-21.85	81.95-109.27			
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	CPI	Day @ 2/3	WEEK @2/3	COMP RATES[2] PER		PAY RATES[3]
DATE	(%)	Day @ ¾	WEEK @3/4		DAY/WEEK	(4 WEEK) 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] PERMONTH [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:
Widow/er only--All
Widow/er--8/11, 1 child--3/11
Widow/er--4/7, 2 children--3/7
Widow/er--8/15, 3/more children, 7/15

Effective 09/07/74:
Widow/er only--All
Widow/er--3/4, 1 child--1/4
Widow/er--3/5, 2/more children--2/5

[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	633.5 - (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 Date	Rate (%)	Days*/Month Since Last CPI		Effective Date	Rate (%)		Days*/Months Since Last CPI
10/01/66	12.5	----	----	04/01/80	7.2	183	6

01/01/68	3.7	457	15	09/01/80	4.0	153	5
12/01/68	4.0	335	11	03/01/81	3.6	181	6
09/01/69	4.4	274	9	03/01/82	8.7	365	12
06/01/70	4.4	273	9	03/01/83	3.9	365	12
03/01/71	4.0	273	9	03/01/84	3.3	366	12
05/01/72	3.9	427	14	03/01/85	3.5	365	12
06/01/73	4.8	396	13	03/01/87	7	730	24
01/01/74	5.2	214	7	03/01/88	4.5	366	12
07/01/74	5.3	181	6	03/01/89	4.4	365	12
11/01/74	6.3	123	4	03/01/90	4.5	365	12
06/01/75	4.1	212	7	03/01/91	6.1	365	12
01/01/76	4.4	214	7	03/01/92	2.8	366	12
11/01/76	4.2	305	10	03/01/93	2.9	365	12
07/01/77	4.9	242	8	03/01/94	2.5	365	12
05/01/78	5.3	304	10	03/01/95	2.7	365	12
11/01/78	4.9	184	6	03/01/96	2.5	366	12
05/01/79	5.5	181	6	03/01/97	3.3	365	12
10/01/79	5.6	153	5	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 .08-.34=.23 Effective .13-.37= .25

11/01/74:	.35-.57=.46	11/01/74:	.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/Penis	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Vulva/Vagina Uterus/Cervix	W	2.05	4.10	6.15	8.20	10.25	20.50	30.75	41.00
	D	14.35	28.70	43.05	57.40	71.75	143.50	215.25	287.00
Larynx/ Tongue	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Eye	W	1.60	3.20	4.80	6.40	8.00	16.00	24.00	32.00
	D	11.20	22.40	33.60	44.80	56.00	112.00	168.00	224.00
Kidney/ Lung	W	1.56	3.12	4.68	6.24	7.80	15.60	23.40	31.20
	D	10.92	21.84	32.76	43.68	54.60	109.20	163.80	218.40
Thumb	W	.75	1.50	2.25	3.00	3.75	7.50	11.25	15.00
	D	5.25	10.50	15.75	21.00	26.25	52.50	78.75	105.00
1st Finger	W	.46	.92	1.38	1.84	2.30	4.60	6.90	9.20
	D	3.22	6.44	9.66	12.88	16.10	32.20	48.30	64.40
Great Toe	W	.38	.76	1.14	1.52	1.90	3.80	5.70	7.60
	D	2.66	5.32	7.98	10.64	13.30	26.60	39.90	53.20
2nd Finger	W	.30	.60	.90	1.20	1.50	3.00	4.50	6.00
	D	2.10	4.20	6.30	8.40	10.50	21.00	31.50	42.00
3rd Finger	W	.25	.50	.75	1.00	1.25	2.50	3.75	5.00
	D	1.75	3.50	5.25	7.00	8.75	17.50	26.25	35.00
Toe other Great Toe	W	.16	.32	.48	.64	.80	1.60	2.40	3.20
	D	1.12	2.24	3.36	4.48	5.60	11.20	16.80	22.40
4th Finger	W	.15	.30	.45	.60	.75	1.50	2.25	3.00
	D	1.05	2.10	3.15	4.20	5.25	10.50	15.75	21.00
Hearing (1 ear)	W	.52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Testicle/ Breast/Ovary*	W	52	1.04	1.56	2.08	2.60	5.20	7.80	10.40
	D	3.64	7.28	10.92	14.56	18.20	36.40	54.60	72.80
Hearing (Both ears)	W	2.00	4.00	6.00	8.00	10.00	20.00	30.00	40.00
	D	14.00	28.00	42.00	56.00	70.00	140.00	210.00	280.00

* Includes Fallopian tube

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/ Penis/	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Vulva/Vagina Uterus/Cervix	W	51.25	61.50	71.75	82.00	92.25	102.50	112.75	123.00
	D	358.75	430.50	502.25	574.00	645.75	717.50	789.25	861.00
Larynx/ Tongue	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Eye	W	40.00	48.00	56.00	64.00	72.00	80.00	88.00	96.00
	D	280.00	336.00	392.00	448.00	504.00	560.00	616.00	672.00
Kidney/ Lung	W	39.00	46.80	54.60	62.40	70.20	78.00	85.80	93.60
	D	273.00	327.60	382.20	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	128.80	144.90	161.00	177.10	193.20
Great Toe	W	9.50	11.40	13.30	15.20	17.10	19.00	20.90	22.80
	D	66.50	79.80	93.101	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 (No Great Toe)	W	4.00	4.8	5.60	6.40	7.20	8.00	8.80	9.60
	D	28.00	33.60	39.20	44.80	50.40	56.00	61.60	67.20
4th Finger	W	3.75	4.50	5.25	6.00	6.75	7.50	8.25	9.00
	D	26.25	31.50	36.75	42.00	47.25	52.50	57.75	63.00
Hearing (1 ear)	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	18.40
Testicle/ Breast/Ovary*	W	13.00	15.60	18.20	20.80	23.40	26.00	28.60	31.20
	D	91.00	109.20	127.40	145.60	163.80	182.00	200.20	218.40
Hearing (Both ears)	W	50.00	60.00	70.00	80.00	90.00	100.00	110.00	120.00
	D	350.00	420.00	490.00	560.00	630.00	700.00	770.00	840.00

* Includes Fallopian tube

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/ Penis/	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Vulva/Vagina Uterus/Cervix	W	133.25	143.50	153.75	164.00	174.25	184.50	194.75	205.00
	D	932.75	1004.50	1076.25	1148.00	1219.75	1291.50	1363.25	1435.00
Larynx/ Tongue	W	104.00	112.00	120.00	128.00	136.00	144.00	152.00	160.00
	D	728.00	784.00	840.00	896.00	952.00	1008.00	1064.00	1120.00
Eye	W	104.00	112.00	120.00	160.00	160.00	160.00	160.00	160.00
	D	728.00	784.00	840.00	1120.00	1120.00	1120.00	1120.00	1120.00
Kidney/ Lung	W	101.40	109.20	117.00	124.80	132.60	140.40	148.20	156.00
	D	709.80	764.40	819.00	873.60	928.20	982.80	1037.40	1092.00
Thumb	W	48.75	52.50	56.25	60.00	63.75	67.50	71.25	75.00
	D	341.25	367.50	393.75	420.00	446.25	472.50	498.75	525.00
1st Finger	W	29.90	32.20	34.50	36.80	39.10	41.40	43.70	46.00
	D	209.30	225.40	241.50	257.60	273.70	289.80	305.90	322.00
Great Toe	W	24.70	26.60	28.50	30.40	32.30	34.20	36.10	38.00
	D	172.90	186.20	199.50	212.80	226.10	239.40	252.70	266.00
2nd Finger	W	19.50	21.00	22.50	24.00	25.50	27.00	28.50	30.00
	D	136.50	147.00	157.50	168.00	178.50	189.00	199.50	210.00
3rd Finger	W	16.25	17.50	18.75	20.00	21.25	22.50	23.75	25.00
	D	113.75	122.50	131.25	140.00	148.75	157.50	166.25	175.00
Toe (Not Great Toe)	W	10.40	11.20	12.00	12.80	13.60	14.40	15.20	16.00
	D	72.80	78.40	84.00	89.60	95.20	100.80	106.40	112.00
4th Finger	W	9.75	10.50	11.25	12.00	12.75	13.50	14.25	15.00
	D	68.25	73.50	78.75	84.00	89.25	94.50	99.75	105.00
Hearing (1 ear)	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Testicle/ Breast/Ovary*	W	33.80	36.40	39.00	41.60	44.20	46.80	49.40	52.00
	D	236.60	254.80	273.00	291.00	309.40	327.60	345.80	364.00
Hearing (Both ears)	W	130.00	140.00	150.00	160.00	170.00	180.00	190.00	200.00
	D	910.00	980.00	1050.00	1120.00	1190.00	1260.00	1330.00	1400.00

* 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

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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 a specified number of weeks of pay. Some separation payments are based on a specific number of weeks of pay, while others are capped at a specified amount of money. However, in order to be equitable to all claimants, offsets for both types of payments should be computed in the same manner regardless of the way the employing agency has offered separation pay. (Lynne M. Schaack, Docket No. 05-695, issued November 9, 2005.)

(1) Where the severance or separation payment is based on weeks of pay,

the CE should suspend compensation payments for the period in question, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the severance or separation pay represents. (See paragraph e. below concerning health benefits and optional life insurance.)

(2) Where the separation payment is based on an amount of money, the CE should:

(a) Calculate the number of weeks worth of salary that the separation pay represents by dividing the total amount of separation pay by the salary used to compute it.

(b) Suspend compensation payments for the number of weeks calculated, effective the date of separation or retirement, by 100% offset for the number of weeks (not the amount of money) which the separation pay represents. (See paragraph e. below concerning health benefits and optional life insurance.

(3) The claimant should be advised that benefits for TTD will cease immediately because he or she has elected to receive severance or separation pay. The claimant should also be advised of the date on which the offset will end.

(4) Where the OWCP later discovers that a severance or separation payment was made for a period when compensation was paid, an overpayment must be declared and the usual due process rights given.

e. Health Benefits (HB) and Optional Life Insurance(OLI).

(1) For claimants with HB and/or OLI coverage, it may continue during the period of severance or separation pay as long as the claimant remains eligible for compensation benefits but for the severance or separation pay and OWCP eventually makes the premium deductions for the time period covered by the severance or separation pay.

(2) The agency will transfer the HB enrollment to OWCP effective the date that employment ceases. The claimant is responsible only for his or her own share of the premiums.

(3) The Temporary Continuation of Coverage (TCC) program allows involuntarily separated employees to continue HB coverage for a short period. The TCC program will not allow a person who is entitled to compensation to enroll, and it will terminate the enrollment of a person entitled to these

benefits.

f. Claims for Additional Compensation.

(1) If a schedule award ends during the period covered by the separation or severance payment, the employee may claim additional compensation for disability (see subparagraph (2) below). If the claimant was not receiving compensation for disability before the schedule award, he or she would not be entitled to receive compensation afterwards unless the medical condition had worsened such that it disabled him or her from the regular or limited duty job performed before separation. Should entitlement to further compensation be established, the employee would need to elect between OWCP and OPM retirement benefits (if eligible).

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

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

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

(5) Employees working part time, or working full time but at lower rates of pay, will be entitled to continue receiving compensation at the end of the period covered by separation or severance pay at the LWEC rate, if injury-related disability continues and they elect OWCP benefits in favor of retirement benefits. Should a recurrence be claimed, it will be the employee's burden to show that injury-related disability has worsened (see subparagraph (2) above). If a formal LWEC decision has been issued, the claimant must establish one of the acceptable criteria for modifying a formal LWEC decision.

(See PM 2-0814.11.)

(6) An employee who was performing regular duty at the time of separation would be entitled to receive compensation only if a true recurrence of disability were established (see subparagraph (2) above).

(7) An employee who accepts separation or severance pay and then changes his or her mind may not receive compensation for the duration of entitlement to separation pay or severance pay. .

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

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02-1100-1 Purpose and Scope

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).

02-1100-2 Authority

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

02-1100-3 Responsibilities of OWCP and SOL

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.

02-1100-4 Letters, Forms and Status Codes

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

02-1100-5 Definitions

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.

02-1100-6 Initial Third Party Screening by the CE

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.

02-1100-7 Administration of Third Party Cases by DCE

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.

02-1100-8 OL Administration and Case Management of Third Party Cases

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.

02-1100-9 Processing the SOR

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.

02-1100-10 Compensation Status Following Refund to the United States

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).

02-1100-11 Establishment of Debt and Debt Management

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.

02-1100-12 USPS Cases

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.

2-1200 FEES FOR REPRESENTATIVES' SERVICES

TABLE OF CONTENTS

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 of administrative costs.

(2) A statement of agreement or disagreement with the amount charged, signed by the claimant. The statement must also acknowledge that the claimant is aware that he or she must pay the fee and that OWCP is not responsible for paying (or reimbursing) the fee or other costs associated with the representative's services.

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	.	COMPENSATION ORDER APPROVAL OF REPRESENTATIVE'S FEE
NAME OF CLAIMANT	.	
		CASE NUMBER:
NAME OF REPRESENTATIVE	.	

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

TABLE OF CONTENTS

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

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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. 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 or CA-5b and it is clear after appropriate development that one or more of the five basic requirements of the claim is not met.

(2) Claims for Compensation. A formal decision is required in any case where the OWCP has received a Form CA-7, claiming compensation, and determined that the claim cannot be paid after appropriate development. Note however that if the case in its entirety (or the same period of compensation) has already been denied by formal decision, a new decision is not needed for a CA-7 received after the date of denial. A letter should be sent to the claimant indicating that the case (or period) has already been formally denied and refer the claimant to any appeal rights that accompanied that decision.

(3) Specific Benefits. If a particular benefit (e.g., a certain kind of medical treatment) must be disallowed, a letter to the claimant explaining why the benefit cannot be granted will often suffice. However, a formal decision should be issued upon any request by the claimant for such a decision.

(4) 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 proposed termination or reduction including the reasons for the proposed action and an opportunity to respond in writing.

(1) Notification 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 for a list of references).

(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).

(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 an authorized representative is present in the case, the CE should also send the letter to the representative.

(5) Subsequent Actions. After releasing the letter, the CE should set a reminder 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. The CE should also prepare a formal decision if the indicated amount of time has elapsed with no response. If an authorized representative is present in the case, the CE must also send the formal decision letter to the representative.

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. The CE may use letters and decisions with pre-formatted text but should modify them, and include additional information as needed, in order to fully explain the findings and rationale for disallowance. See paragraph 5 below concerning preparation of decisions which are not pre-formatted.

d. Signature Authority. Designated CEs at the GS-12 level may deny the following: initial claims for traumatic injury and occupational disease; most complex disability and death cases; 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 ratable loss; and periods of intermittent wage loss where the claimant has not met the burden of proof to establish entitlement to compensation. Designated CEs at the GS-12 level also issue 0% Loss of Wage-Earning Capacity (LWEC) decisions and render decisions on disputed attorney fee requests up to $10,000.

All other disallowances will be prepared for the signature of the Senior Claims Examiner (SrCE). Signature authority parameters are outlined fully in Exhibit 11.

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.

(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

2-1400 Exhibit 2: Sample Letter Conveying Proposed Termination

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

2-1400 Exhibit 11: Signature Authority (Approvals/Denials/Certification)

GENERAL GS-12 CLAIMS EXAMINERS

* Traumatic Injury Claims
* Occupational Disease Claims
* Most Complex Disability and Death Cases
* Medical Treatment, Equipment, Supplies
* Surgery Requests
* Recurrences
* Non-Ratable Hearing Loss
* COP
* Intermittent Wage Loss
* 0% LWECs
* Disputed Attorney Fees ($0-$10,000)

* Payment Certification ($0-$15,000; including signature on CA-181 when certifying payment within prescribed limit) Note: Lump sum schedule award calculations must also be approved by a SCE.

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
* Disputed Attorney Fees ($0-$15,000)
* 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 on the payment sheet with an annotation of 'Acting SCE.'
* Payment in excess of $99,999 must be certified by the Assistant District Director (ADD) or District Director (DD).
* SCE – Disputed Attorney Fees ($0-$50,000)
* DD or ADD – Disputed Attorney Fees > $50,000

2-1500 RECURRENCES

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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 from 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. Recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, non-performance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations. See 20 C.F.R. 10.5(x).

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; however, see part 5 in this section where an LWEC rating is in place. 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 (Terry L. Hedman, 38 ECAB 222). In Hedman, ECAB found that when an employee, who is disabled from the job he held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he can perform the light-duty position, the employee has the burden of establishing by the weight of the reliable, probative and substantial evidence a recurrence of total disability and to show that he cannot perform such light duty. As part of his burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements. However, an increase in pain does not constitute objective evidence of disability. See Sally S. Weinacht, Docket No. 91-1035, issued November 12, 1991.

(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 LWEC decision will remain in place. Any claim for a recurrence of disability should be treated as a request for a modification of a LWEC, and not as a recurrence of disability. See, PM Chapter 2-814-11.

There is no basis for disturbing the 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.

See Debbie A. Titus, Docket No. 05-360 (issued June 3, 2005). ECAB held that the claimant had failed to establish a modification of her LWEC. ECAB stated that the fact that the claimant's temporary limited duty appointment had expired was no basis for modifying the wage-earning capacity determination. ECAB stated: "Compensation for loss of wage-earning capacity is based upon loss of the capacity to earn and not on actual wages lost. So it makes no difference whether the temporary appointment expired or the employing establishment simply withdrew limited duty: Appellant continued to have a capacity to earn wages, as the Office

determined in its November 24, 1999 decision. Absent a showing that the November 24, 1999 wage-earning capacity determination should be modified, appellant has no disability under the Act and is not entitled to compensation for 'wage loss' after June 27, 2003."

See also James D. Nardo, Docket No. 04-2209 (issued May 5, 2005), footnote 17: "This position was found to reflect a no loss in wage-earning capacity. [ECAB] notes that the above-described criteria for modifying formal loss of wage-earning capacity decisions remains the same regardless of whether a given claimant continues to work or stops work after the issuance of a formal loss of wage-earning capacity decision."

If the evidence establishes a basis for modification, payment of appropriate compensation should be made.

FECA PM 2-0814.12 and 20 C.F.R. 10.509 address situations where employment is terminated due to a RIF, downsizing 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.

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

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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

TABLE OF CONTENTS

1. **Purpose and Scope**. This chapter describes the processing of requests for hearings. The procedures include review of the case file, arrangements for the hearing, conduct of the hearing, and issuance of the decision. Additionally, procedures are described for handling requests for review of the written record. These functions, along with pre-recoupment hearings in overpayment cases (see FECA PM Part 6), are the responsibility of the Branch of Hearings and Review (H&R) within DFEC's National Office.

2. **Policy**. This paragraph describes the scope of claimants' entitlement to hearings and reviews of the written record.

a. Right to a Hearing. Where the injury or death occurred on or after July 4, 1966, the claimant is entitled to a hearing before an Office representative after a final decision and before reconsideration under Section 5 U.S.C. 8128. For injuries or diseases prior to that date, the Employees' Compensation Appeals Board (ECAB) has ruled that claimants are not entitled to a hearing as a matter of right but that the OWCP has the discretionary authority to grant a claimant's request for a hearing regardless of the date of injury or death (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.

3. **Applications**. Requests for hearings and reviews should be mailed directly to the Branch of Hearings and Review in Washington, DC. This requirement and the appropriate address are clearly outlined in the appeal rights provided to claimants.

While all requests should be directed to H&R, some may be received in the DO. They should be handled as follows:

a. Branch of Hearings and Review. When the request for a hearing or review is sent to H&R, the request will be date stamped. Additionally, the envelope and request will be scanned into the case file.

b. District Office. If a request is received in the DO, H&R should be notified as soon as possible so that an H&R record can be created and the request can be tracked. The DO should notify H&R by advising the Branch Chief and Assistant Chief via e-mail of the untracked hearing request.

c. Acknowledgment. H&R will acknowledge receipt of the request by computer-generated letter, providing the claimant and representative of general information about the hearing process.

4. **Initial Review of the Case**. Upon receipt of the hearing request, H&R staff will review it to determine whether a reconsideration preceded the request for a hearing or review, whether the request is timely, whether all necessary evidence is on record, and, if so, whether it supports the decision of the DO.

a. Timeliness. The request is timely if it was mailed (as determined by the postmark or other carrier's date marking) within 30 days of the date of the district office's decision. 20 C.F.R. §10.616. If the postmark is not legible, the request will be deemed timely unless the Office has kept evidence of date of delivery on the record reflecting that the request is untimely. In cases where the instructions on the appeal rights that accompanied the decision were not followed and the hearing request was received by the DO and then forwarded to H & R, H & R will review the available evidence and determine the timeliness of the request.

b. Entitlement.

(1) Hearing. If preliminary study shows that the decision was reached in accordance with established policies and is supported by the evidence of record, the case will be scheduled for a hearing as described in paragraph 6 below. If a review has been requested, the procedures described in paragraph 5 below will be followed.

(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 district office decision aside. This order will include the reasons for the decision to remand and will outline the further action needed. A formal decision vacating the contested decision and a cover letter will also be prepared.

(3) Simultaneous ECAB Appeal. Only one avenue of appeal per decision on a particular issue can be pursued at one time. See *Douglas E. Billings,* 41 ECAB 880 (1990). In instances where a claimant requests a hearing or review through H&R and the ECAB on the same issue simultaneously, the Board will take precedence and have jurisdiction over the issue concurrently appealed. In these cases, the Hearing Representative will contact the claimant and inform him/her (and authorized representative, if applicable) that H&R is precluded from reviewing the issue currently before the Board. If the claimant wishes to proceed through H&R, he/she will have to contact the Board and request to withdraw the appeal. Once the Board has accepted the withdrawal request and dismissed the appeal, H&R will proceed with the review of the record or the hearing. The Hearing Representative will ensure that the record reflects all communications relating to these instances.

5. **Review of the Written Record**. This paragraph discusses the steps involved in processing requests for review of the written record.

a. H&R will furnish the employing agency with a copy of the claimant's request for review of the written record, together with any pertinent factual documentation submitted. (Medical evidence is not considered "pertinent" for review and comment by the agency and will therefore not be furnished to the agency. The OWCP has sole responsibility for evaluating medical evidence.)

b. The agency will be allowed 20 days to submit any comments and/or documents believed relevant and material to the issue in question. H&R will furnish any comments or documents submitted by the agency to the claimant and allow 20 days for review and comment by the claimant. 20 C.F.R. §10.618(b).

c. 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. Appeal rights will be attached to any adverse decision.

6. **Arranging for Hearings**. This paragraph addresses the steps involved in arranging for a hearing and discusses some of the issues which may arise in obtaining evidence.

a. OWCP Discretion. Claimants are notified in their appeal rights that at H&R's discretion, an oral hearing may be conducted by teleconference or videoconference. H&R will therefore schedule an oral hearing and determine whether that hearing will be conducted in person or via teleconference, videoconference or other electronic means. See 20 C.F.R. §10.616(b).

b. Scheduling. A written notice specifying the exact date, time, format, and place for the hearing will be mailed at least 30 days prior to the scheduled hearing. The claimant, the claimant's authorized representative, and the employing agency will be provided with such written notice.

In instances where a claimant requests an appeal through H&R and the ECAB simultaneously, the Hearing Representative will advise all parties that although a hearing will be scheduled, if the Board does not release the case prior to the hearing date, said hearing will be cancelled and rescheduled once the Board releases the record.

c. Employing Agency Participation. When the hearing is scheduled, the employing agency will be advised that its representative may be present at the proceedings and/or receive a copy of the hearing transcript. The agency may, in the discretion of the Hearing Representative, send more than one representative. 20 C.F.R. §10.621(a). Agency representatives attend primarily as observers and may not participate in the hearing unless the claimant or the Hearing Representative specifically requests them to do so. A notice to the employing agency will accompany the agency's copy of the letter to the claimant scheduling the hearing.

d. Record of the Hearing. H&R will arrange to record the testimony provided at the hearing, and it will then be transcribed. The transcript of the

hearing is the official record of the hearing. (20 C.F.R. §10.616(d)). The actual recording (i.e. magnetic tape) is the property of the reporting contractor and cannot be made available to the parties involved. Audiovisual coverage of hearings is not permitted, and claimants may not use their own recording equipment.

e. Withdrawal of Hearing Requests. The claimant may withdraw the request for hearing at any time by written notice, or on the record at the hearing. If the request is withdrawn, no further requests for a hearing on the decision at issue will be considered.

f. Postponement of Hearing Requests. Once an oral hearing is scheduled and H&R has mailed appropriate written notice to the claimant and representative, H&R will, upon submission of proper written documentation of unavoidable serious scheduling conflicts (such as court-ordered appearances/trials, jury duty or previously scheduled outpatient procedures), entertain requests from a claimant or his representative for rescheduling as long as the hearing can be rescheduled on the same monthly docket, generally no more than 7 days after the originally scheduled time. In these instances, rescheduled hearings will usually be held via teleconference, and the Hearing Representative will ensure that the file accurately reflects any action taken to reschedule the hearing. When a request to postpone a scheduled hearing cannot be accommodated on the docket, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly. 20 C.F.R. §10.622(c).

Where the claimant or representative is hospitalized for a non-elective reason, or where the death of the claimant's or representative's parent, spouse, child, or other immediate family member prevents attendance at the hearing, the OWCP will, upon submission of proper documentation, grant a postponement beyond one monthly docket. 20 C.F.R. §10.622(d)

All decisions regarding rescheduling of hearings as described under Section 10.622 of the CFR, subsections (b) through (d), are within H&R's sole discretion.

g. Abandonment of Hearing Requests. A claimant who fails to appear at a scheduled hearing may request in writing within 10 days after the date set for the hearing that another hearing be scheduled. Where good cause for failure to appear is shown, another hearing will be scheduled and conducted by teleconference. The second hearing will be scheduled as soon as possible but usually no later than 35 days from the date it is requested unless good cause is shown to reschedule at a later date.

The failure of the claimant to request another hearing within 10 days, or the failure of the claimant to appear at the second scheduled hearing without good cause shown, shall constitute abandonment of the request for a hearing. Where good cause is shown for failure to appear at the second scheduled hearing, review of the matter will proceed as a review of the written record. Hearing Representatives will ensure that the record is properly documented to reflect all changes made concerning rescheduling and changes in format.

Where it has been determined that a claimant has abandoned his/her right to a hearing, H&R will issue a formal decision finding that the claimant has abandoned his or her request for a hearing. In cases involving pre-recoupment hearings, H&R will issue a final decision on the overpayment based on the available evidence before returning the case to the DO. 20 C.F.R. §10.622(f).

h. Subpoenas. A claimant may request a subpoena for documents and/or the attendance and testimony of a witness; however, the decision to grant or deny such a request is within the discretion of the hearing representative. See 20 C.F.R. §10.619.

(1) Subpoenas for documents are issued only if such evidence is relevant and cannot be obtained by other means. Subpoenas for the attendance and testimony of a witness are issued only where oral testimony is the best way to ascertain the facts.

(2) A subpoena request must be made in writing no later than 60 days (as evidenced by postmark, electronic marker, or other objective date marker) after the original hearing request.

(3) The subpoena request must designate the witness or documents to be produced, and clearly describe the address and location of the witness or documents to be subpoenaed. The request must also explain why the testimony or evidence is directly relevant to the issues at hand, and must demonstrate that a subpoena is the best and only method or opportunity to obtain such evidence. The Hearing Representative has the discretion to decide that such facts could be established by other evidence without the issuance of a subpoena.

(4) If H&R determines that issuance of a subpoena is reasonably necessary for the full presentation of the case, a subpoena will be issued in the name of the Hearing Representative which compels the attendance of witnesses.

(5) The OWCP shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the Office. The claimant shall pay fees requested by witnesses who have submitted evidence into the case record at the request of the claimant. In order to reduce reimbursement costs to either party, H&R will, at its discretion, change the hearing format so that witnesses whose attendance is compelled by subpoena can participate by telephone.

(6) If H&R determines that issuance of a subpoena is not reasonably necessary to present the case fully, a formal denial of the request for subpoena, with an explanation for such denial, will be included with the final decision (see paragraph 8e below).

7. **Conduct of Hearings**. This paragraph describes the steps involved in the hearing itself.

a. Nature of Proceedings. Hearings will be open to claimants, their representatives, witnesses, designated agency officials, and any other

persons whose presence the Hearing Representative deems necessary. The proceedings are informal and are not limited by legal rules of evidence or procedures. The proceedings are limited to one hour; however, this limitation may be extended in the discretion of the Hearing Representative. The testimony will be taken under oath and recorded verbatim.

b. Preliminary Matters. Before opening the proceedings, the Hearing Representative will explain to all parties present that hearings are non-adversarial in nature and that the claimant will have the opportunity to present any written or verbal evidence desired.

c. Opening the Hearing. At the beginning of the proceedings, the Hearing Representative will:

(1) Note the date and time;

(2) Identify all persons present by name;

(3) Administer an oath to all persons testifying;

(4) Make an opening statement which outlines the issues in question and ask the claimant if he/she concurs; and

(5) Afford the claimant (or his/her representative) an opportunity to make an opening statement.

d. Presentation. The claimant may offer material in any manner desired. Written evidence offered should be acknowledged and made a part of the record. If the hearing is conducted via telephone or video, the claimant will be asked to discuss the evidence that he/she wishes to make part of the record. The hearing representative will then inform the claimant that the evidence discussed should be forwarded to the Office for inclusion into the file. If the hearing is conducted in person, the claimant will be asked to discuss the evidence that the/she wishes to make part of the record, and the Hearing Representative will mark such evidence and introduce it into the record. The Hearing Representative will ensure that the evidence handed to him/her at the hearing is scanned into the case file. During the presentation, the Hearing Representative should note any additional questions or areas for exploration and make appropriate inquiries before terminating the hearing.

e. Conclusion. When all witnesses have spoken, and the Hearing Representative has obtained all necessary clarification, the Hearing Representative will close the proceedings by noting the time of completion. The record will remain open for the submission of additional evidence for 30 days after the hearing is held. At the sole discretion of the Hearing Representative, one brief extension may be granted after the initial 30 days.

8. **Reaching a Determination**. In this paragraph, the actions taken after the hearing are described.

a. Comments. The claimant (or the authorized representative) and the employing agency will be provided with a copy of the transcript. The employing agency will be allowed 20 days from the release of the transcript to

submit any comments and/or documents believed relevant to the issue in question. Any comments or documents submitted by the agency will be forwarded to the claimant or his/her representative with the opportunity to submit written comments within 20 days.

b. Further Development. If additional development is needed, the case may be remanded to the DO. However, if the issue can be resolved readily, the Hearing Representative will undertake the additional development and incorporate the results into the decision.

c. Schedule Awards. The OWCP adopted the Third Edition of the AMA Guides to the Evaluation of Permanent Impairment effective March 8, 1989; the revised Third Edition of the Guides effective September 1, 1991; the Fourth Edition effective November 1, 1993; the Fifth Edition effective February 1, 2001; and the Sixth Edition effective May 1, 2009. Any recalculations of previous awards which result from Hearings and Review decisions issued on or after May 1, 2009, should be based on the Sixth Edition of the Guides. However, if the percentage of the award is affirmed but the case is remanded for further development of some other issue, e.g. pay rate, recalculation of the percentage of the award under the Sixth Edition is not required.

Where a calculation under the Sixth Edition results in a lower impairment rating to a schedule member than the original award under the Fifth Edition, the Office (consistent with past practice) will make the finding that the claimant has no more than the percentage of impairment originally awarded; that the evidence does not establish an increased impairment; and that an overpayment will not be declared.

However, if a schedule award decision is set aside (after a hearing or review by the ECAB, or as part of the reconsideration process), and additional development is undertaken to resolve the schedule award issue, a new schedule award decision should be issued that fully addresses the reasons for the change in rating. Declaring an overpayment thereafter is appropriate if the later decision substantiates a lesser degree of impairment than previously awarded, so long as both ratings are based on the same edition of the AMA Guides.

Similarly, if a claimant requests an increased schedule award due to a belief that his or her medical condition has deteriorated since the original award was issued, and additional development is undertaken to address this claim for an increased award, a new schedule award decision should be issued that addresses and substantiates the newly determined impairment rating. If a lesser degree of impairment than previously awarded is substantiated, an overpayment thereafter is appropriate, so long as both ratings are based on the same edition of the AMA Guides.

Where a schedule award decision establishes a lesser impairment after a greater award has been paid, the resulting overpayment will have a finding of without fault.

d. Final Decision. When all evidence and testimony has been evaluated, the Hearing Representative will issue a decision which affirms, reverses,

remands, or modifies the District Office 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 appeal rights will be noted.

9. **District Office Actions**. Any case requiring further action based on a decision issued by H&R should be promptly assigned to a CE for the required action.

a. Timeliness of Action. Substantive action should be taken within 15 days of return of the case file.

b. Reinstatement of Benefits. If the hearing decision concludes that the Office did not meet its burden of proof before reducing or terminating benefits, the following actions will be taken:

(1) The Hearing Representative will instruct the claimant or representative of his/her right to file Form CA-7 (or, in the case of death benefits, Form CA-12) to claim compensation.

(2) Upon receipt of the completed form, the 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, including a Form CA-1032 as necessary.

(4) The Form CA-7 is intended to cover the entire period during which benefits were terminated or reduced. Only one Form CA-7 need be completed. In general, further payments should be made on the periodic roll.

c. Review of the Remand Decision. If the District Office, upon careful review, believes the remand decision issued by the Branch of Hearings and Review contains a serious error of fact or law, the District Director should contact the Hearings and Review Branch Chief (or Assistant Branch Chief) within 15 days of receipt of the decision outlining the basis for the disagreement. This review process, rarely employed, should be reserved for cases where there is a material factual error or a misinterpretation of the statute, regulations, or procedures that is critical to the decision. If, upon review of the decision, the Hearings and Review Branch Chief determines that the decision issued was in error, the decision may be vacated through 5 U.S.C. 8128, which provides for review of a decision allowing or denying compensation “at any time.” If, upon review of the decision, the Hearings and Review Branch Chief determines that the decision issued was appropriate, no action will be taken. This process does not apply to Employing Agencies.

This process also does not apply to claimants or their authorized representatives, since appeal rights are issued with every decision issued by the Branch of Hearings and Review.

2-1602 RECONSIDERATIONS

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1. Purpose. This chapter outlines procedures for handling reconsideration requests. It describes the filing requirements, the tests for sufficiency of applications, and the actions required to process them. All such requests are handled within the district office having jurisdiction of the case.

2. Policy. The following policy considerations pertain to all requests for reconsideration:

a. Requirements. A claimant may apply for reconsideration of a final decision regardless of the date of injury or death. While no special form is required, the request must be in writing, be signed and dated by the claimant or the authorized representative and be accompanied by relevant new evidence or argument not considered previously. The request should also identify the decision and the specific issue(s) for which reconsideration is being requested. The request must be received within one year of the date of the contested decision if that date was after June 1, 1987 (see paragraphs 4d and 4e below).

b. Assignment and Signature Level. Each request for reconsideration must be handled by a Senior Claims Examiner (SrCE) who was not involved in making the contested decision (with one exception, described in paragraph 3c below). All reconsideration decisions, whether affirmative or negative, must be issued by a SrCE or higher authority.

c. Timeliness for Issuing Decisions. The goal for issuing reconsideration decisions is 90 days from receipt of the request. To meet this goal, a final decision must be issued. In a case requiring further development it is not sufficient to vacate the previous decision and return the case to the responsible Claims Examiner (CE) for further action.

3. Preliminary Processing.

a. Review of Request. The CE will receive a reconsideration request in the incoming mail. Upon receipt of a request, the CE should refer the request to the designated individual who assigns reconsiderations (this will vary by district office). That individual will assign the reconsideration request to a SrCE who was not previously involved in the contested decision.

(1) The request does not have to be submitted on the appeal request form; letter format is acceptable.

(2) The word “reconsideration” does not need to be stated in the request for it to be considered valid, but sufficient detail should be provided to discern the decision being contested.

(a) If the claimant does not state the date of the specific decision contested, the CE, SrCE, or the designated individual should review the reconsideration request and determine whether a final decision has been released on the issue for which reconsideration is requested.

(b) If no final decision has been released on the issue or the contested decision cannot be reasonably determined from the claimant's request, the CE, SrCE, or designated individual should return a copy of the application to the claimant for clarification and

inform the claimant that OWCP will take no further action on the request unless clarification is submitted. (This action is not a denial of application and should not be reported as a reconsideration decision; if such a request had been entered into the tracking system it should be deleted.)

(c) An example of "reasonably determined" includes an instance where only one final decision was issued in the case file so it can be reasonably determined that the one denial decision is the one being contested.

b. If a claimant is seeking an increased schedule award due to increased impairment and/or additional exposure, but not contesting the decision or prior award, this should not be treated as a reconsideration request. The responsible CE should develop entitlement to an additional award.

c. Non-receipt of a completed CA-1032 or CA-12. When compensation has been suspended for failure to submit a CA-1032 or CA-12 form, the claimant or beneficiary may request a reconsideration accompanied by a completed Form CA-1032 or CA-12. In this case, the CE currently assigned to the case may act on the reconsideration request and restore benefits since submission of the form itself satisfies the requirement for reinstatement. No reconsideration assignment to a SrCE is necessary, but the CE should notify that the claimant or beneficiary that benefits have been reinstated.

4. Time Limitations. OWCP's regulations at 20 CFR 10.607(a) establish a one-year time limit for requesting reconsideration. The one-year period begins on the date of the original decision, and an application for reconsideration must be received by OWCP within one year of the date of the OWCP decision for which review is sought for merit decisions issued on or after August 29, 2011.

a. A right to reconsideration within one year accompanies any subsequent merit decision. This includes any decision issued by the Branch of Hearings and Review (H&R) after a hearing or review of the written record, any denial of modification following a reconsideration, any merit decision by the Employees' Compensation Appeals Board (ECAB), and any merit decision following a remand from H&R or ECAB, but does not include pre-recoupment hearing decisions.

b. The SrCE should review the file to determine whether the application for reconsideration was received within one year of a merit decision. Timeliness is determined by the document receipt date of the reconsideration request [the "received date" in the Integrated Federal Employees' Compensation System (iFECS)]. If the request for reconsideration has a document received date greater than one year, the request must be considered untimely.

c. The one-year time limit to file a reconsideration request does not include any time following the decision that the claimant can establish (through medical evidence) an inability to communicate and that his testimony would be necessary. (See 20 CFR. 10.607(c); John Crawford, 52 ECAB 395 (2001))

d. Decisions Issued Before June 1, 1987. No time limit applies to requests for reconsideration of these decisions because there was no regulatory time limit for requesting reconsideration prior to June 1, 1987. Therefore, a request for

reconsideration may not be denied as untimely **unless** the claimant was advised of the one-year filing requirement in a later decision denying an application for reconsideration or denying modification of the contested decision. In these cases, the one-year time limit begins on the date of the decision that includes notice of the time limitation.

e. Decisions Issued on or after June 1, 1987 through August 28, 2011. For decisions issued during this period, there is still a one-year time limit for requesting reconsideration. The one-year period begins on the date of the original decision, and the application for reconsideration must be mailed to OWCP within one year of the date of the OWCP decision for which review is sought.

5. Untimely Applications. The regulations at 20 CFR 10.607(b) provide that OWCP will consider an untimely application for reconsideration only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision.

a. Clear Evidence of Error. The term "clear evidence of error" is intended to represent a difficult standard. The claimant must present evidence which on its face shows that OWCP made a mistake. For example, a claimant provides proof that a schedule award was miscalculated, such as a marriage certificate showing that the claimant had a dependent but the award was not paid at the augmented rate. Evidence such as a detailed, well-rationalized medical report which, if submitted before the denial was issued would have created a conflict in medical opinion requiring further development, is not clear evidence of error. (Dean D. Beets, 43 ECAB 1153 (1992); Leona N. Travis, 43 ECAB 227 (1991)).

b. If clear evidence of error has not been presented, the request should be denied according to 20 CFR 10.608(b). The SrCE should deny the application by letter decision, which includes a brief evaluation of the evidence submitted and a finding that clear evidence of error has not been shown. The claimant's only right of appeal from this decision is to ECAB.

c. If clear evidence of error has been presented with an untimely application, the SrCE should issue two separate formal decisions. The first decision will deny the application due to timeliness; this can be a letter decision. The second is a merit review on the Director's own motion. Section 8128 of the Federal Employees Compensation Act provides the authority for the Secretary of Labor to review an award for or against payment of compensation at any time on the Director's own motion. This review may be made without regard to whether there is new evidence or information. See 20 CFR. 10.610.

(1) If the Director, or a designated person acting on the Director's behalf, determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director or designee, (at any time and on the basis of existing evidence) may modify, rescind, decrease, or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to a request or petition and none shall be entertained.

(2) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this

discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(3) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review or not to review an award is not reviewable, i.e., is not subject to appeal.

6. Timely Applications. In accordance with the regulations set forth in 20 CFR 10.606, a timely application for reconsideration must be accompanied by specific evidence or argument.

a. Evidence or Argument Required. All requests for timely reconsideration should be accompanied by one of the following:

(1) Argument that the OWCP erroneously applied or interpreted a point of law. 20 CFR 606(b)(3)(i). For example, the CE failing to use the Shadrick formula when calculating a loss of wage earning capacity (LWEC), or failing to include all appropriate elements of pay when determining a pay rate for compensation purposes.

(2) Relevant legal argument not previously considered by OWCP. 20 CFR 606(b)(3)(ii). A statement from the claimant that he or she simply does not agree with basis of the decision does not constitute relevant legal argument. The statements or documentation submitted by the claimant would need to be accompanied by a legal premise material to the denied issue in order to have a reasonable color of validity for reopening of the case for further review on the merits.

For example, in a case that was denied on the basis of a medical opinion of a referee specialist, the introduction of evidence to support a prior connection between the referee physician and the employing agency would be sufficient to require the Office to reopen the case for a review of the merits. While a reopening of a case may be predicated solely on a legal premise not previously considered, such reopening for further review on the merits is not required where the legal contention does not have a reasonable color of validity. See Cleopatra McDougal-Saddler, 50 ECAB 367 (1999), which indicates that an application should contain at least the assertion of an adequate legal premise, or the proffer of proof, or the attachment of a report or other form of written evidence, material to the kind of decision which the applicant expects to receive as the result of his application for reconsideration. See also Thomas D. Joy, Docket No. 98-1086 (issued March 16, 2000) (ECAB found appellant's arguments concerning procedural flaws in the hearing (including bias) lacked sufficient color of validity and did not warrant a reopening of his case for a review of the merits of his claim.)

(3) New evidence (not previously considered by OWCP) which is relevant to the issue upon denial. 20 CFR 606(b)(3)(iii). For example, the submission of a witness statement would be considered relevant if the claim had been denied because fact of injury had not been established. Such a statement would not be relevant if the claim had been denied because the claimant had

not submitted medical evidence addressing causal relationship. See Matthew Diekemper, 31 ECAB 224 (1979) (new evidence which is submitted but is irrelevant to the pertinent issue is not sufficient to reopen the case on the merits). If the new medical reports are repetitious and cumulative of evidence previously submitted, they have no evidentiary value and do not constitute a basis for reopening the claimant's case. (Bruce E. Martin, 35 ECAB 1090, 1093-94; Eugene F. Butler, 36 ECAB 393 (1984). Evidence that is essentially duplicative (such as a duplicative narrative) does not form a basis for reopening a claim.) (See James W. Scott, 55 ECAB 606 (2004).)

b. Evaluating Sufficiency of Evidence. When the request for reconsideration is accompanied by new evidence, the SrCE must determine whether it is sufficient to review the case on its merits. This step requires careful review of the file to assess what material it already contains. Such examination should not be confused with a merit review of the case.

(1) Nature of Evidence. The following kinds of evidence are not sufficient to reopen the claim for merit review:

(a) Cumulative evidence, which is substantially similar to material on file and has already been considered. For example, chart notes from the attending physician with new dates but similar content to those already of record and considered previously. See Jacqueline M. Nixon-Steward, 52 ECAB 140 (2000) (Physician reports were similar to previously submitted reports).

(b) Repetitious evidence, which consists of copies of previously submitted evidence which was already considered in the contested decision. For example, a duplicate medical report that was already considered. See David J. McDonald, 50 ECAB 185, 190 (1998) (Documents previously considered by the Office).

(c) Irrelevant or immaterial evidence which has no bearing on the issue or which is frivolous or inconsequential in regard to the issue. For example, a knee injury was claimed but the medical submitted pertains to a back condition or a case was denied on Fact of Injury (FOI)-factual but medical evidence is submitted. See Linda I. Sprague, 49 ECAB 386 (1997).

(2) The 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.

c. Based on review of the evidence submitted in conjunction with the case file, the SrCE must then decide whether a merit review should be performed, or whether the application for such a review should be denied.

Where the application is accompanied by new and relevant evidence or by an arguable case for error, the SrCE should conduct a merit review of the case to determine whether the prior decision should be modified. See paragraph 8. If the

only evidence submitted is cumulative, repetitious or irrelevant, or no evidence is submitted, a non-merit decision should be issued. See paragraph 7.

7. Non Merit Decisions. A timely application for review that is not supported by additional evidence or argument for error in fact or law is insufficient to warrant a merit review of the case.

For example, if a claimant submits a letter or appeal request form identifying the contested decision but provides no accompanying statement or additional evidence, or provides only cumulative, repetitious or irrelevant evidence, a non merit review decision should be issued. See 20 CFR 10.608(b).

a. Protecting Claimant's Further Appeal Rights. The ECAB will accept appeals filed up to 180 days from the date of the last merit decision. If a reconsideration decision is delayed beyond 90 days, the claimant's right to review of the original decision by the ECAB is abrogated.

When a reconsideration decision is delayed beyond 90 days, and the delay jeopardizes the claimant's right to review of the merits of the case by the Board, OWCP should conduct a merit review. That is, the basis of the original decision and any new evidence should be considered and, if there is no basis to change the original decision, an order denying modification (rather than denying the application for review) should be prepared. There is no obligation to conduct a merit review on insufficient evidence if the maximum 180 day time limit for requesting review by the Board will have expired within the 90 day period following the OWCP's receipt of the claimant's reconsideration request. See C.L., Docket No. 10-1483 (May 12, 2011).

b. Decision. If the evidence submitted is not sufficient to require a merit review, the SrCE should issue a decision which discusses the evidence submitted, or lack thereof, and explicitly state the basis for the finding of insufficiency. The decision should explain that the application for reconsideration is denied on the basis that the evidence submitted in support of the application is not sufficient to warrant review.

(1) The SrCE should be careful not to include any language suggesting that a review on the merits of the claim was undertaken. Statements about whether an identical or similar document or opinion was found in the file are appropriate. Evaluative statements regarding new or old evidence, such as “the evidence lacks substantial probative value,” are not appropriate.

(2) If no evidence is submitted with the application for reconsideration, a letter decision is adequate.

(3) If evidence is submitted, a Notice of Decision in addition to the cover letter should usually be provided in order to adequately discuss the deficiencies in the evidence.

(4) The claimant's only appeal from this decision is to request review by the ECAB.

8. **Merit Reviews**. Where the application is accompanied by new and relevant evidence or by an arguable case for error, the SrCE should conduct a merit review of the case to determine whether the prior decision should be modified.

a. Notice to Employing Agency. As soon as the SrCE decides that an application is sufficient to warrant a merit review of the case, the employing agency should be notified; however, the requirement to provide a copy of the application and the evidence received differs depending on whether the issue for determination is medical in nature. See 20 CFR 10.609(a).

(1) Where there is a legal argument or factual basis for the merit review, the application together with copies of pertinent supporting documentation should be sent to the employing agency. The cover letter should explain that the employing agency may submit comments and/or documents but that any evidence must be received within 20 days. The employing agency should also be advised that any comment or evidence received is subject to review by the claimant.

Medical evidence submitted with the request shall not be furnished to the employing agency, since it does not constitute documentation that is "pertinent" for review and comment by the employing agency.

(2) Where a reconsideration request pertains only to a medical issue (such as disability or a schedule award), the employing agency should be notified that a request for reconsideration has been received, but no comments should be solicited from the employing agency if medical evidence is the sole basis for the review.

(a) OWCP is not required to wait 20 days for comment before reaching a determination, except when the claimant is deployed in an area of armed conflict.

(b) The SrCE may provide notification of such a reconsideration request via the telephone. In this instance, the SrCE should document the file with a CA-110 noting the agency representative who was provided with the notification.

(3) Any evidence submitted by the employing agency should be forwarded to the claimant with a letter allowing 20 days for comment before a final decision is issued on the reconsideration request.

(4) The 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 issue and maintain jurisdiction over it until a final decision is reached. A SrCE has no authority to remand or return a case to a CE for further development actions.

(a) If an initial stress claim is received on reconsideration, the SrCE should handle all appropriate adjudicatory actions pertaining to that particular claim. For example, if new evidence is submitted supporting a factor(s) of employment as work-related and casual relationship is

now at issue, the SrCE should prepare a Statement of Accepted Facts (SOAF) and refer the claimant for a second opinion examination.

(b) If a schedule award claim is received on reconsideration, the SrCE should handle the case until a determination is made regarding the percentage of impairment. For example, if the claimant is disputing the percentage of award and submits new evidence, the case should be referred back to the DMA if appropriate, or for further examination if needed.

Note - OWCP adopted the Sixth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment effective May 1, 2009. Any recalculations of previous awards based on a prior edition of the Guides, which result from a reconsideration decision issued on or after May 1, 2009, should be based on the Sixth Edition of the Guides. See PM 2-808 for further discussion of appropriate actions after recalculation of a previous award.

(2) Any party from whom additional evidence is required should be asked to submit it within 20 days, so that the reconsideration request may be adjudicated within the 90-day time frame. If information requested from a claimant is not submitted in a timely manner, modification may be denied on the basis that the evidence is insufficient.

c. Decisions. After any necessary development, the SrCE should issue one of the following formal decisions:

(1) Deny modification of the prior decision. If the evidence submitted is insufficient to alter the prior decision, the SrCE should deny modification of the prior decision. To deny modification of the prior decision, the SrCE should prepare a formal decision discussing the evidence received and include a detailed explanation why the evidence is not sufficient to modify the prior decision rendered. Such a denial does not carry the right to a hearing/review but does carry the right to request reconsideration again, or review by the ECAB.

(2) Vacate the prior decision. If a previous decision is to be vacated and a condition, period of disability, etc. is to be newly accepted, the SrCE should prepare a decision to vacate and a cover letter which describes the acceptance in specific terms. The decision should explicitly point to the evidence used to vacate the denial and provide a brief discussion as to how it is sufficient to overturn the prior decision. If this decision represents the initial acceptance for the claim, an acceptance letter with the attachment “Now That Your Claim Has Been Accepted” should be sent with the decision

(3) Modification of the prior decision. Such a decision does not carry the right to a hearing/review but does carry the right to again request reconsideration or review by the ECAB.

(a) To modify an initial denial from one of the five basic elements to another, the SrCE should prepare a decision explaining why the evidence is now sufficient to meet the prior element denied, but still insufficient to meet the next element(s). For example, if a case was

previously denied on FOI-Factual for the reason that the claimant had not sufficiently explained how the injury occurred, and the claimant submitted a detailed factual statement with his/her reconsideration request that now meets FOI-Factual, but the case file remains devoid of a valid diagnosis, then the decision needs to explain that OWCP is modifying the prior decision to now meet FOI-Factual but the case remains denied on FOI-Medical.

(b) If a prior decision is to be affirmed in part and modified/vacated in part, the SrCE will need to prepare a decision which incorporates both the previous and new findings. The cover letter to the claimant should describe in detail the elements of the new decision, explicitly stating which findings and/or conclusions are affirmed and which findings and/or conclusions are being modified. For example, all benefits, both compensation and medical, were terminated and upon reconsideration, the claimant submitted supportive medical evidence that indicates further medical treatment is still required. The termination of compensation benefits is affirmed but the decision to terminate all medical benefits is vacated. The reconsideration decision should explicitly explain that the evidence still supports that the work-related disability has resolved and therefore compensation benefits remain terminated. However, the new evidence submitted upon reconsideration now supports the work-related condition has not resolved and the claimant remains entitled to medical benefits.

2-1603 APPEALS

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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

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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.

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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.

2-1700 Exhibit 1: Annual Pay Rates

ANNUAL PAY RATES
FOR COMPUTING COMPENSATION
OF PEACE CORPS AND VISTA VOLUNTEERS

Date of Injury	PC Volunteer	VISTA Volunteer	PC Volunteer Leaders/Heads of Households
09/22/61-10/13/62	$ 5,355	5,355	7,560
10/14/62-01/04/64	5,540	5,540	8,045
01/05/64-07/04/64	5,795	5,795	8,410
07/05/64-10/09/65	6,050	6,050	8,650
10/10/65-07/02/66	6,269	6,269	8,921
07/03/66-10/07/67	6,451	6,451	9,221
10/08/67-07/13/68	6,734	6,734	9,657
07/14/68-07/12/69	6,981	6,981	10,203
07/13/69-12/27/69	7,639	7,639	11,233
12/28/69-01/09/71	8,098	8,098	11,905
01/10/71-01/08/72	8,582	8,582	12,615
01/09/72-01/06/73	9,053	9,053	13,309
01/07/73-10/13/73	9,520	9,520	13,996
10/14/73-10/12/74	9,969	9,969	14,671
10/13/74-10/11/75	10,520	10,520	15,481
10/12/75-10/09/76	11,046	11,046	16,255
10/10/76-10/08/77	11,523	11,523	17,056
10/09/77-10/07/78	12,336	12,336	18,258
10/08/78-10/06/79	13,014	13,014	19,263
10/07/79-10/04/80	13,925	13,925	20,611
10/05/80-10/03/81	15,193	15,193	22,486
10/04/81-10/02/82	15,922	15,922	23,566
10/03/82-01/07/84	16,559	16,559	24,508
01/08/84-01/05/85	17,138	17,138	25,366
01/06/85-01/03/87	17,824	17,824	26,381
01/04/87-01/02/88	18,358	18,358	27,172
01/03/88-12/31/88	18,726	18,726	27,716
01/01/89-01/13/90	19,493	19,493	28,852
01/14/90-01/12/91	20,195	20,195	29,891
01/13/91-01/11/92	21,023	21,023	31,116
01/12/92-01/09/93	21,906	21,906	32,423
01/10/93-09/30/93	21,906	21,906	33,623
10/01/93-01/07/95	22,717	18,340	33,623
01/08/95-01/06/96	23,171	18,707	34,295
01/07/96-01/04/97	23,634	19,081	34,981
01/05/97-01/03/98	24,178	19,520	35,786
01/04/98-01/02/99	24,734	19,969	36,609
01/03/99-01/01/00	25,501	20,588	37,744
01/02/00-01/13/01	26,470	21,370	39,178
01/14/01-01/12/02	27,185	21,947	40,236
01/13/02-01/11/03	28,164	22,737	41,684
01/12/03-01/10/04	29,037	23,442	42,976
01/11/04-01/08/05	29,821	24,075	44,136
01/09/05-01/07/06	30,567	24,677	45,239
01/08/06-	31,209	25,195	46,189

2-1800 HOUSING & VEHICLE MODIFICATIONS

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* (ENTIRE CHAPTER REISSUED 10/09, TRANSMITTAL NO. 10-03)

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 maintain or increase independence and quality of life, and, consequently, may reduce the need for future services and their associated costs. Modifications may in some circumstances also reduce or delay the need for residential care and nursing services.

2-1800-2 Authority

2. Authority. Housing and vehicle modifications come under the authority of 5 U.S.C. 8103(a) which provides for services, appliances and supplies prescribed or recommended by a qualified physician, which the Secretary considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation. See, D.T., Docket No. 05-1012 (issued August 23, 2006) (ECAB held that OWCP has broad administrative discretion in choosing the means to achieve the goals of section 8103 of the FECA. As the only limitation on the OWCP's authority is reasonableness, abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions which are contrary to both logic and probable deductions from known facts).

2-1800-3 Eligibility

3. Eligibility. To be eligible for housing or vehicle modifications, the claimant must be severely restricted in terms of mobility, functionality and independence in normal living functions, on a permanent basis, due to the work-related injury. Examples are impairments that require the use of a prosthesis, wheelchair, motorized scooter, leg braces, crutches, cane, or other self-help device. Such medical conditions include quadriplegia, paraplegia, amputation, total loss of use of limbs, blindness and profound deafness bilaterally.

2-1800-4 Medical Development

4. Medical Development. When a request is received for housing or vehicle modifications, the Claims Examiner (CE) should take initial action within five working days of receipt. The CE should ensure that the original acceptance of the case was proper and that the disability for which the benefit is claimed is related to the accepted injury.

Before considering the technicalities of housing and vehicle modification proposals (paragraphs 5, 6 and 7 below), a determination must be made on the medical necessity of the requested modification. See William D. Farrior, 54 ECAB 566 (2003) (ECAB held that OWCP properly exercised its discretionary authority in denying appellant's request for a new vehicle, as there was insufficient rationalized medical evidence addressing appellant's physical restrictions due to his accepted knee conditions or the need for a motor vehicle modification or new vehicle purchase.)

There are several aspects to consider when reviewing the evidence of record:

(1) Does the level of impairment rise to the level delineated in the eligibility section above?

(2) Does the medical evidence support that the claimant has restrictions or physical limitations which necessitate the modification?

(3) Are these restrictions caused by the accepted work-related condition?

(4) Does the physician provide detailed findings and rationale for the opinion that the claimant's work injury has caused restrictions which necessitate the requested modification? This should come from a physician who is a recognized authority in

the appropriate medical specialty.

Note that the modification should result from a restriction. For example, the purchase of a wheelchair or scooter for a claimant does not necessarily mandate that the concomitant modification to a vehicle be made. If the restriction leading to the wheelchair/scooter also prevents the claimant from driving without it, then the vehicle modification would be compensable. On the other hand, if the scooter was provided because the claimant cannot walk long distances but is able to drive an unmodified vehicle, then the OWCP is not responsible for vehicle modifications. In this instance, there is no injury-related restriction that requires the claimant to drive a modified vehicle. (See, M.B., Docket No. 06-701 (issued December 4, 2006) (ECAB held that appellant's physician did not explain why appellant's employment-related accepted conditions required medical treatment which could only be accommodated by purchase of a van.)

If the evidence of record fails to establish medical necessity in consideration of the above criteria, the claimant should be provided with 30 days to submit the needed medical documentation. The questions to the physician should be specific in regard to the injury related restriction which necessitates the requested modification.

Requests for modification are not routinely sent to the District Medical Advisor (DMA). However, if there is a complicated medical issue that requires DMA review, the medical evidence should be forwarded to the DMA for an opinion on the necessity and work-relatedness of the requested modification(s).

If medical eligibility is established, then the CE should proceed with the technical development of the proposed modification in conjunction with the criteria outlined in paragraphs 5, 6 and 7 by requesting a detailed proposal for the requested modifications. These proposals will address the technical, financial and practical elements of the requested modifications. Under certain circumstances, OWCP may assist in developing such proposals by referring the case to a Rehabilitation Specialist (RS), who will assign a Rehabilitation Counselor (RC) to assist the claimant in developing a detailed proposal for the requested modifications. The case may also be referred to a Field Nurse (FN) in some instances to assist with this process.

If the proposed modification is not supported, a formal decision is required as outlined in paragraph 8.

2-1800-5 Vehicle Modifications

5. Vehicle Modifications.

a. General Criteria. No vehicle modification should be undertaken without a signed agreement that specifies the nature of the modification and the claimant's responsibilities and obligations under the agreement.

(1) Modifications to a vehicle must be established as necessary and desirable for increased mobility or independence by a recommendation of a physiatrist or other medical specialist appropriate to the type of injury sustained. The medical evidence must establish that the requested

modifications are needed because of restrictions caused by the accepted condition(s). See paragraph 4.

(2) Modifications of the present vehicle must be explored before considering a new purchase.

(3) Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. If accessories and equipment are needed for the claimant's present vehicle, OWCP will modify it if it is practical to do so, as determined by the type of vehicle, its age and condition, and the type of equipment needed.

(4) If it is established that the claimant cannot drive his or her present car due to the inability to place a wheelchair in it without assistance, or if it is not practical to modify the present vehicle, OWCP will pay for a suitable car or van (if necessary), taking credit for the trade-in value of the vehicle with the greatest current fair market value owned by the claimant; however, OWCP will not be named on the title for the vehicle.

(a) If the claimant purchases a used car, OWCP will pay the depreciated price of a base-line, otherwise comparable, used car or van of comparable age and condition, with equipment required for the accepted disability. The claimant is responsible for paying the difference between the new or used vehicle allowed by OWCP and the car or van actually purchased and additionally equipped as the claimant desires.

(b) If the claimant purchases a new car or van, OWCP will pay the discounted price of a base-line vehicle of suitable size. The base line vehicle is the most cost effective model upon which the necessary modifications can safely be made. OWCP will also pay the discounted price for additional options required for the effects of the injury and any necessary after-market add-ons, such as hand controls. Wherever possible, optional equipment should be factory-installed.

(5) If a car or van must be purchased by OWCP, it will be the most cost-effective modifiable model with the optional equipment required for the effects of the injury. Hand controls or other special devices will be added to it. If the claimant desires a model that is more costly because of nonessential factors, or desires accessories not required for the injury, he or she must pay the difference in price. OWCP will pay only the discounted price for the suitably sized base-line vehicle with the necessary options and modifications. The claimant will pay any difference resulting from the selection of a more expensive model and/or additional accessories not necessitated by the injury.

(6) Modifications and the additional costs of a new vehicle (when warranted) over the value of the present vehicle will be paid for by OWCP. When a new or used vehicle is purchased, the amount paid by OWCP will be

reduced by the trade-in value of the vehicle owned by the claimant with the greatest current fair market value.

(7) Vehicle modifications should be no more expensive than necessary to accomplish the required purpose. Special hand and foot controls and any items which need not be built in should be removable where feasible for transfer to other vehicles.

(8) Vehicle modifications may include what are normally considered comfort or convenience options, if documented by the medical specialist to be necessary for the effects of the compensable disability. In specific cases, it would be appropriate to make payment for such equipment as air conditioning, power brakes, power steering, automatic transmission, power door locks, power windows, rear defogger, or six-way power seat.

(9) Equipment furnished for a vehicle by OWCP should be maintained and repaired at OWCP expense and may be replaced after normal wear and tear. Equipment required for the injury will be repaired and maintained at OWCP expense. Other parts of the vehicle will be repaired, maintained and replaced at the owner's expense even if OWCP paid for the vehicle. Replacement equipment for the present vehicle or similar equipment will be provided on a replacement vehicle if the claimant can establish that the vehicle should be replaced. OWCP may only consider the purchase of a subsequent vehicle when the estimated cost of reasonable mechanical repairs on the current vehicle exceeds its lowest current Blue Book value.

(10) The claimant is required to provide proof of adequate insurance and proper registration of the vehicle in the state of residency. The costs of insurance and registration are the responsibility of the claimant. Claimants are required to carry fire, theft, comprehensive and collision insurance on vehicles paid for in whole or in part by OWCP, but need not maintain collision insurance if the equipment furnished is worth under $200.

(11) The Government is entitled to reimbursement for the value of the modifications when relinquished or no longer needed by the claimant, if the value of the modifications exceeds $10,000 at that time. Reimbursement is due to the Government only in situations where the claimant has had use of the vehicle or vehicle modifications for less than ten years. The value of a vehicle purchased for a claimant, or of automotive accessories such as power steering, automatic transmission and power door locks, will be determined by the lowest current Blue Book figure when the vehicle is sold, traded, or no longer needed by the claimant.

At the time the vehicle or automotive accessory is sold, traded, or otherwise disposed of, the current value of the item is reduced by 10 percent for each year used by the claimant in order to obtain the figure for reimbursement. For example, where the value of the modified vehicle is $10,000 at the time of disposal and the claimant has used it for six years, reimbursement to the

Government should be $4,000. The CE should multiply 10 percent by the number of years used (.10 X 6=.60), and multiply the result by the current value of the modified vehicle (.60 X $10,000=$6,000), and subtract the result from the current value ($10,000-$6,000=$4,000) to obtain the reimbursement amount. If the current value is less than $10,000, the above formula will not be applied and the claimant will not be required to reimburse OWCP.

(12) The claimant (and authorized representative if applicable) should be notified of these reimbursement requirements and should sign an acknowledgment of these reimbursement responsibilities. See Exhibit 1.

b. Technical Development.

If medical eligibility has been satisfied, the claimant should be advised of the criteria mentioned in this section. Specifically, the claimant should be notified from the outset that an existing vehicle will be modified whenever feasible, but that any new or used vehicle purchased must be at the discounted price of the most cost-effective base-line vehicle of suitable size, taking credit for the trade-in value of the claimant's present vehicle. If the claimant owns more than one vehicle, the vehicle with the greatest current fair market value will be used to calculate trade-in value. The additional expense of a higher priced vehicle or personal preference options will normally be the claimant's obligation.

When possible, the claimant should submit at least three estimates. An OWCP RC may assist as needed. If it is not possible to obtain 3 bids, the reason should be documented for the record.

Proposals should include the following information:

(1) An itemization of all vehicle modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical rehabilitation professional familiar with the needs of the disabled. When the cost for modifications exceeds $1,000, the professional proposing the modifications must ensure that his or her report justifies the need for and adequacy of the proposed modifications.

(2) Vehicle modification proposals must include the year, make, model and body style of the present vehicle, the number of miles it has been driven, and a description of its general mechanical condition, including any repairs currently needed or anticipated.

(3) If the evidence supports that the claimant’s current vehicle cannot be modified and a new vehicle must be purchased, then additional information is needed. Estimates should be provided for the most cost-effective model that can be modified. If the base-line model

available comes with extras (like a CD player), then these need not be deducted from the estimate. Any additional options which are not included in the baseline model and not necessitated by the work injury (e.g., a sunroof) are the financial responsibility of the claimant and should be deducted from the estimate.

(4) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with a proposal. Approved representative's fees remain the claimant's obligation, as discussed in FECA PM 2-1200.

2-1800-6 Housing Modifications for Home Owners

6. Housing Modifications for Home Owners.

a. General Criteria. No housing modification should be undertaken without a signed agreement that specifies the nature of the modification and the claimant's responsibilities and obligations under the agreement.

(1) Housing modifications must be recommended by a physiatrist or other medical specialist appropriate to the accepted employment condition as necessary and desirable for increased mobility or independence. Before proceeding with a housing modification, the medical recommendation must be current and supported by adequate medical rationale. Rehabilitation services should then be utilized in conjunction with the medical recommendations in order to assist with an on-site visit by a RC or other medical rehabilitation professional. The purpose of the on-site visit will be to provide a report of general requirements that will be necessary to accomplish the medically necessary housing modifications. In addition, the RC or other medical rehabilitation professional will assist in locating architects to draw up plans for modifications when needed, and contractors for building and installing the modifications.

(2) Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical. The purpose of the FECA is not to provide an enrichment program in proportion with the severity of the injury sustained. To do so would extend the program beyond the intent and scope of the FECA which is to provide an adequate substitute for an employee's loss of earning ability to provide for his or her living needs. For example: If a claimant must purchase or build a new home because the current residence would not be structurally sound to modify, the new residence must be comparable in size (i.e. square feet of living area) and quality to the currently owned home. Or, if new doors and special door knobs must be installed in the claimant's residence, the quality of the hardware and finish of the doors, the hardware itself, and any molding should be comparable to those being replaced. See Janice Kirby, 47 ECAB 220 (1995) (ECAB held that OWCP did not abuse its discretion to restrict benefits under section 8103 to the new construction of those items necessary to accommodate appellant's injury-related condition. In this case, appellant's

parents acknowledge that the construction of the new home intended to accommodate appellant was based on personal and financial considerations and not on the structural unsoundness of appellant's existing home.)

(3) In analyzing a housing modification proposal, it is OWCP's policy to fully explore modifications to a present house before consideration of a purchase or building of a new home. If the claimant elects to purchase a new home or build a new structure, for any reason other than that it would be structurally unsound to attempt to modify the present house, it must be made clear that the OWCP is responsible only for the modifications and relevant plans for the new house which are necessitated by the work injury. In such a situation, OWCP is not responsible for the cost of the new house. The only situations which warrant that the OWCP be involved with helping to purchase or build a new home is where it would be impossible to make the necessary modifications to the present home or that such modifications would cause structural damage to the house.

(a) OWCP will not find that the purchase of or building of a new home is warranted solely on the basis that modifying the present home is too costly. As long as the needed modifications can be achieved without structural damage to the property, OWCP will cover the cost. Also, it would not be considered sufficient reason for the OWCP to assist in the purchase or construction of a new house if the claimant finds that it would be aesthetically undesirable to make an addition to his or her present home. In addition, a claimant's concern that modifications will negatively affect the home's property value is insufficient to warrant purchasing or building a new home for modification rather than modifying the existing structure.

(b) The claimant is required to establish with written certification from at least two professional sources that his or her present home is not structurally modifiable. Such certification from an architect or a licensed building contractor must include a full explanation of why the present home is not structurally modifiable. The OWCP RC may also assist with obtaining this information.

(c) If it is accepted that the present home cannot be structurally modified, other existing home purchase options must be explored and precluded prior to considering new construction. New construction will generally add more delays, time and money, as well as a degree of complexity, and therefore should only be considered if no other option exists. Justifications for construction of a new house must be related to the work injury and not on the basis of personal preference.

(d) Where the present home cannot be modified without structural damage, OWCP will be responsible for the difference between the cost of the new house and that of the existing house. If the claimant purchases a house that represents an increase in his or her standard

of living, due to personal preference, the cost of the upgrade will be the claimant's responsibility. For example: If the claimant owns a house worth $100,000 with a mortgage at the time of sale of that house of $85,000, his or her position at the time of purchasing or building the new home should be that he or she owes $85,000 on the new mortgage. OWCP does not purchase the house but will make up the difference up to the worth of the present residence, i.e., $100,000. In such a case, the responsibility of OWCP would also include housing modifications and modifications to the architectural plans. See, e.g., Wayne G. Rogers, 54 ECAB 482 (2003). However, OWCP is providing purchase assistance and is not purchasing the house. Therefore, neither OWCP nor any Government agency will be named on the deed to the house in such an arrangement.

(4) If the claimant lived in his or her own house at the time of injury and makes the decision to buy or build a new home for reasons other than those described above, OWCP will pay only the cost of modifying a suitable house. The OWCP will not pay moving expenses. If the claimant decides on his or her own to purchase or build a new house, the OWCP will only pay any extra expenses in altering the plans and for medically necessitated modifications to the new house.

(5) Modifications will be consistent with the current home and no more expensive than necessary to accomplish the required purpose. For example, in remodeling a bathroom, it may be feasible to remove and reinstall an existing sink to wheelchair height, rather than discard it and buy a new sink. If the existing sink cannot be used, purchase of the most cost-effective comparable sink that will fulfill the purpose of providing accessibility will be approved. Another example involves access issues related to ramps, lifts and elevators. When determining the most appropriate mode of access to or within a home, the most cost-effective modification should be selected. Each item for modification should be assessed in terms of safety, accessibility and cost-effectiveness, as well as meeting the injured worker's pre-injury standard of living, as is practical. The specification of a particular product brand should be avoided unless it is established that a single name brand is the most cost-effective means of meeting the requirement for the modification.

(6) The cost-effectiveness of modifications to meet a temporary need, when the physician anticipates a prolonged recovery, should be considered against long-range tangible and intangible benefits, such as facilitating recovery, reducing the length of hospitalization or confinement in other care facilities, or reducing the need for an attendant.

(7) Modifications may include what are normally considered to be comfort or convenience accessories, if needed for the effects of the compensable injury. In specific cases, special heating, air conditioning and air filtration devices may be necessary based on the nature of the accepted condition. For

example, such items might be required for an individual with a respiratory or cardiac ailment, and the physician recommending the accessories would be responsible to explain such needs. In addition, if a generator is being requested, the CE should consider if there is equipment that needs to be backed up by a generator in the event of a temporary power outage in order to preserve health or life.

(8) Once a Housing Modification Plan is approved, any changes to the OWCP funded modifications must be submitted by the contractor. The changes must be approved by OWCP via written change orders prior to the change being initiated, unless the change is related to items that the claimant will be responsible for paying.

(9) Once the housing modification is approved, the contractor may find more extensive repairs are needed in order to pass inspection. For example, after tearing down a wall more extensive work is needed due to problems hidden by the wall. While the repairs may not be specifically related to the disability, the contractor cannot proceed without correcting the new problem. These additional repairs should be approved if necessary to complete the approved modifications.

(10) Contractors are required to provide proof of license and insurance. Prior to authorizing a plan, the local licensing board or other similar entity should be contacted by the RC to insure that there are no significant infractions reported against the contractor, such as poor work or fraudulent activity.

(11) The RC must verify local permit requirements. Permits are to be obtained in localities where they are required. If no permit is required and completed work is questionable, OWCP can pay for a 3rd party inspection such as a city or county building inspector.

(12) Equipment required due to the work injury and furnished by OWCP for the present house or new house will be maintained, repaired and replaced as needed after normal wear and tear at OWCP expense.

(13) The claimant is required to provide proof of adequate insurance. Claimants must carry home owner's insurance that reflects the present value of their house, unless the modifications were furnished at a cost under $1,000.

(14) The Government is entitled to reimbursement for the value of any housing modifications when relinquished or no longer needed by the claimant if the value at that time exceeds $10,000 after applying a sliding scale, which is explained below. When disposing of modified property, the sliding scale must be applied to any enhanced value over $10,000, and that amount must be returned to the Government. See Minne B. Lewis, 53 ECAB 606 (2002) (ECAB upheld OWCP's repayment provisions as they "prevent unjust

enrichment." ECAB stated that without them a claimant who has received a Government subsidy to purchase property could turn a quick profit by simply selling the property. OWCP procedures requiring reimbursement to the government attempt to return the claimant, after the property is relinquished, to substantially the same position he or she enjoyed previously.)

For example, if an elevator is installed in the claimant's house and the house is later sold, the OWCP should be reimbursed from the proceeds of the sale for the current value of the elevator, if it exceeds $10,000 after applying the sliding scale. The current value may be determined in any reasonable, equitable manner, such as estimates from real estate sources, bank appraisers, or by comparing recent sale prices of similar houses without the special equipment.

A sliding scale is used to determine the remaining enhanced value at the time the house or housing modification is relinquished or no longer needed by the claimant. The amount of reimbursement due to the Government will be reduced gradually. If the claimant leaves the modified home after one year of residence, the amount of reimbursement due the Government would be 90% of the total disbursements made for the purchase and/or housing modifications. After two years of residence in the modified home, the amount of the reimbursement to be sought by OWCP would be 80% of the disbursements. The amount of the reimbursement due the Government would continue to reduce annually, with a reduction to zero after ten years of residency has elapsed.

While some modifications may decrease rather than increase the value of a home, no reimbursement to the claimant can be made for any reduction in the value of the house resulting from modifications which may inconvenience prospective purchasers.

(15) The claimant (and authorized representative if applicable) should be notified of these reimbursement requirements and should sign an acknowledgment of these reimbursement responsibilities. See Exhibit 2.

(16) If a house has been modified, the claimant must notify OWCP before any move which may result in a claim for further housing modifications. A claimant who sells a modified house is liable for modifying any future residence absent a claims-related reason for the move and prior OWCP approval (see paragraph 10 below).

b. Technical Development. If medical eligibility has been satisfied, the claimant should be advised of the criteria mentioned in this section. Specifically, The claimant should be advised that proposed housing modifications should be of a quality and finish level consistent with his or her present residence but not superior to it. (For example, builder grade cabinets will be replaced with similar cabinets, not expensive custom cabinets). Likewise, proposals should mention the type of materials being

used rather than concentrating on a specific brand name. The most cost-effective means of accomplishing the modification should be provided in the proposal. The claimant should also be advised that if it is established that it is not structurally feasible to modify the present residence, a move to a comparable residence which could be properly modified should be considered. While it is the claimant's own decision, OWCP will not pay for modifications that would compromise the structural soundness of the residence.

When possible, the claimant should submit at least three bids in the proposal. Typically, an OWCP RC will assist with this process. If it is not possible to obtain three bids, the reason should be documented for the record. The bids should be commensurate in the level of detail provided and address all needed modifications so that comparisons between them will be accurate. Bids should be submitted by licensed and insured contractors.

Proposals should include the following information:

(1) Three bids which contain an itemization of all modifications proposed. The materials, labor, and associated fees for accomplishing these modifications should be listed and a time frame for completing them provided. Only modifications approved by the OWCP (based on medical evidence) will be paid for by the OWCP. Additional modifications and/or optional material upgrades are the responsibility of the claimant. For ease of comparison, each bid should separate the costs assumed by each party (claimant and OWCP) where necessary.

(2) When the cost for modifications exceeds $5,000, the RC coordinating the modifications must ensure that an on-site review is performed to justify the need for and adequacy of the proposed modifications. Reasonable fees will be paid for the medical rehabilitation professional's visit to the home and detailed recommendations. If necessary, the RC can utilize an accessibility specialist and OWCP will pay a reasonable fee for an on-site analysis. Documentation of the site visit should be included with the proposal.

(3) If construction work is required, a binding estimate of the cost from three reputable contractors is needed. Customarily, no fee will be paid for such bids, since they are normally supplied to prospective purchasers free of charge. Reasonable fees for bids can be considered for extensive home modifications if it can be established that it is the usual practice for the extent and degree of the home modification in the specific locale. Reasonable fees will be paid for preliminary architect's sketches when significant structural changes requiring architectural services are needed. If special accessories or devices are requested, the CE should stipulate that the price given by the vendor includes any necessary installation. The bid selected will be the lowest of any acceptable means of achieving the desired result. The lowest prices will be accepted unless there is sound reason for a higher price,

such as increased durability or degree of contractor experience and/or established record of working with accessibility design issues.

(4) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with a proposal. Approved representative's fees remain the claimant's obligation, as discussed in FECA PM 2-1200.

2-1800-7 Housing Modifications for Renters

7. Housing Modifications for Renters.

a. General Criteria. The status of renter includes claimants who are or were living with parents or other family members at the time the work injury occurred. Modifications to rental property must be approved by the property owner. A signed agreement is required which acknowledges that the modifications are being paid for because the property owner has agreed to house the claimant and further acknowledges the property owner's reimbursement responsibilities to OWCP. No housing modification should be undertaken without this kind of signed agreement that specifies the nature of the modification and the claimant's, as well as the home owner's or apartment owner's, responsibilities and obligations under the agreement. See Exhibit 3 or 4 depending on whether the claimant is renting or living with a family member.

Many of the criteria outlined in paragraph 6 for home owners apply also to claimants who rent housing. A few specific criteria for renters are below:

(1) In a rental property, all modifications proposed must be recommended by a 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 CE and approved as necessary and desirable for increased mobility or independence.

(2) If the claimant lives in rented premises, a statement from the property owner authorizing the proposed changes should be included in the proposal. This includes a situation in which the claimant is living in a parent's or other relative's home. OWCP should conduct a conference with the landlord to assess the level of commitment to continue renting to the injured worker after the modifications are accomplished. There should be some level of assurance that the landlord will continue to rent the modified property to the injured worker for an extended period of time considering the extent and cost of the modifications.

(3) If the claimant is renting and the owner of the property will not permit necessary modifications, other living arrangements may be subsidized, such as paying moving expenses to other rented quarters as comparable as possible to the present residence. OWCP should also pay any difference in rent. However, a claimant who is renting his or her living quarters should not expect any assistance from OWCP for purchasing or constructing a new

house.

(4) Modifications to 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 sinks will be replaced or modified in order to preserve the symmetry of the room. If the tile in the bathrooms or kitchen needs to be replaced in order to accomplish the proposed modification, the new tile should be of a quality equal to that which must be replaced.

On the other hand, just as in a privately-owned residence, cost-effectiveness and practicality are essential criteria to be used when considering proposed modifications. If an existing sink can be reinstalled at another height [see this chapter paragraph 6.a(5)] to achieve the required modification, this is preferable to discarding it and replacing it with a new sink.

(5) Similarly, when a claimant lives in a rented walk-up 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.

(6) If a renter living in a remote area needs a modification not allowed by the property owner, and there is no rental property available within a reasonable distance, the feasibility of relocation, new construction, or any other viable option should be weighed.

(7) For true rental situations, the claimant is required to provide proof of adequate insurance. Claimants must carry renter's insurance that reflects the present value of the belongings within the residence, unless the modifications were furnished at a cost under $1,000. If the claimant is living with a family member, the home owner should carry the insurance.

b. Technical Development. The technical development of the housing modification will take the same course for renters as for the home owners described in the prior paragraph, with the exception that the landlord or home owner must agree to the modifications.

2-1800-8 Adjudication of Proposals

8. Adjudication of Proposals.

a. Medical evidence as described in paragraph 4 above is required. A claimant seeking a housing or vehicle modification should be advised to submit the requested documentation needed to establish medical necessity. If the claimant fails to submit the necessary documentation, a formal decision with appeal rights should be issued. This decision should discuss the evidence of record and provide an explanation of why it is insufficient to support the medical necessity. Technical development of a

proposal, or review of a submitted proposal, is not necessary if the evidence of record does not establish that the proposed modifications are necessitated by work-related restrictions.

b. If medical necessity is established, then technical development to establish the criteria noted in paragraphs 5, 6 or 7 is warranted. As noted previously, it is often necessary to have an OWCP RC or FN involved in this process. The CE will review the itemized proposal and determine whether the specified modifications are warranted. This would be an appropriate time for a telephone conference between the CE, the claimant, the RS, the RC, the FN and the party performing the modification (as appropriate) to discuss the proposal, particularly if changes to, or clarification of, the proposal are needed before authorization can be given.

c. The CE's recommendations for approving proposals are to be routed to the Senior Claims Examiner (SrCE), regardless of the cost involved. If the proposal is approved, the SrCE should send an approval letter along with a written agreement which details the terms and conditions of the authorization (see Exhibits 1-4).

d. If the recommendations are denied, in whole or in part, a formal decision with appeal rights is to be drafted for the signature of a SrCE or higher. If the recommendations require further development, the case should be returned to the CE with appropriate comments and instructions.

2-1800-9 Payment for Modifications

9. Payment for Modifications.

a. SrCEs are required to review all proposals and may authorize housing and vehicle modifications in amounts up to $50,000. Supervisory Claims Examiners are authorized to approve housing and vehicle modifications in amounts up to $100,000. Housing and vehicle modifications in amounts over $100,000 are to be approved by the Assistant District Director or District Director.

b. Bills including installation work or construction work must be accompanied by the claimant's (or the RC's) statement showing that the work covered by the payment has been accomplished satisfactorily. Construction expenses should be paid promptly as the job progresses, to coincide with "draws" on the claimant's construction contract.

2-1800-10 Later Requests for Modification

10. Later Requests for Modification. After a vehicle or house has been modified, the claimant may request modification of a different vehicle or house.

a. Vehicle. It is expected that even a vehicle which is regularly maintained will eventually require replacement. Its value should be determined by the lowest current Blue Book figure when the vehicle is sold, by the actual purchase price, or by the trade-in value, whichever is highest. The amount should be subtracted from the cost of any new vehicle authorized.

b. House. Payment for modification of a subsequent house for both home

owners and renters may be authorized under very limited circumstances. Any subsequent move must be undertaken for a reason related to the claim, and detailed rationale should be provided before the move is to occur. Acceptable reasons include the need to obtain more sophisticated medical care or a medical need to live in a different environment. Reasons not accepted as justification for modification of a different house include personal preference for a
different locale or the desire to be closer to family for additional support. If the reason given is deemed acceptable, the CE should document the file to reflect this decision so that any expenditure in modifying the new house can be justified. See e.g. John Yera, Docket No. 00-2476 (issued June 18, 2002) (ECAB held that OWCP was within its guidelines and discretion in denying appellant's request for a modification of a different residence as appellant voluntarily transferred to Virginia in an effort to utilize his specialized skills in the area of Internet crimes. ECAB found that the reasons advanced by appellant for accepting the position in Virginia were neither persuasive nor convincing to justify an approval of a modification to a second home.)

2-1800-Exhibit 1 (Vehicle Modification)

Memorandum of Agreement – Vehicle Modification

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the purchase of and/or the modifications to your vehicle. These vehicle modifications are approved based upon limitations caused by your accepted work injury.

The undersigned agree to the following:

1. OWCP will pay for the purchase of the following vehicle and the specific modifications identified below. In purchasing your vehicle, OWCP will take credit for the trade-in value of the vehicle you own with the highest current fair market value.

   For new vehicle purchase, list trade-in vehicle, approved new vehicle and all approved modifications.

   OR

   OWCP will pay for the specific modifications to your existing vehicle as identified below.

   For existing vehicle modifications, identify existing vehicle and list all approved modifications.

2. You will provide proof of adequate insurance and proper registration of the vehicle in the state of residency. You are required to carry fire, theft, comprehensive and

collision insurance on vehicles paid for in whole or in part by OWCP, unless the equipment furnished is worth under $200. You understand that you are responsible for paying annual taxes, insurance costs, and all registration fees for the vehicle.

3. Equipment required for your injury and furnished for your vehicle by OWCP will be repaired and maintained at OWCP expense. All other parts of the vehicle will be repaired, maintained, and replaced at your expense even if OWCP has paid for the vehicle.

4. You understand that if and when the vehicle, item, or modification is no longer needed, you will be entitled to retain it if the value (or enhanced value) is less than $10,000. If the value of a vehicle, an enhancement to a vehicle, or any other item furnished for your vehicle is greater than $10,000 when relinquished by you, the amount of value above $10,000 must be reimbursed to the Department of Labor in a percentage of the total value based on the period of use. If you have used the vehicle, enhancement, or other item for one year, the amount to be reimbursed to the Department of Labor would be 90% of the value above $10,000. The amount to be reimbursed will be reduced by 10% annually until it reaches zero (0%) after 10 years of your use.

By signing this agreement, all parties indicate an understanding of and agreement with the conditions set forth above regarding the vehicle purchase and/or modifications.

_____ Date: _____
Claimant
CLAIMANT NAME

_____ Date: _____
Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Agreement Prepared By:

Name:
Title:
Date:

2-1800-Exhibit 2 (Housing Modification)

Memorandum of Agreement – Housing Modification

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for modifications to your property at **ADDRESS.** These housing modifications are approved based on limitations caused by your accepted work injury.

The undersigned agree to the following:

1. You agree to the renovations described below. OWCP will pay for these modifications, and only these modifications, as described in the attached document from **CONTRACTOR NAME**.

   List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work, etc.

2. You will notify OWCP before any move which may result in a claim for a new house or a claim for modifications on a new house.

3. You agree that you will provide proof of adequate insurance, including home owner's insurance that reflects the value of your house, upon completion of the approved renovations. You will send proof of insurance to OWCP once renovations have been completed.

4. You must notify OWCP if you intend to relinquish your ownership of the house.

5. You understand that the Government is entitled to reimbursement for the value of the home modifications described in this agreement if the property is relinquished or the modifications are no longer needed if the value at that time exceeds $10,000. If the value is greater than $10,000 when relinquished or no longer needed by you, the amount of value above $10,000 must be reimbursed to the Department of Labor in a percentage of the total value based on the period of use. The Government agrees that the value of the home modifications will decrease at the rate of 10 percent of the total per year for every year that you reside at the property. For example: If the home modifications are completed in December of 2009 and you reside in the house until December of 2015, the value of the renovations would have decreased by 60% in that time. The Government at that time would be entitled to reimbursement for 40% of the amount paid for the modifications. If you live in the home and require the modifications for 10 years, the Government is no longer entitled to any reimbursement amount. The government will not seek reimbursement of any amount until you no longer have need for the modifications or the home.

By signing this agreement, all parties indicate an understanding of and agreement with the conditions set forth above regarding the housing modifications to be completed at **ADDRESS.**

_____ Date: _____
Claimant
CLAIMANT NAME

_____ Date: _____
Co-owner(s) of the home (if applicable)
CO-OWNER'S NAME

_____ Date: _____
Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Agreement Prepared By:

Name:
Title:
Date:

2-1800-Exhibit 3 (Rental Property Modification)

Memorandum of Agreement – Modification to Rental Property

(Office of Workers' Compensation Programs and Claimant)

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the modification of an apartment to be used as your primary residence. The apartment at **ADDRESS** is a **#** bedroom, **#** bath unit with **#** square feet. The initial length of lease will be **#** years.

The undersigned agrees to the following:

1. OWCP will pay for modifications to the apartment and building common areas as detailed below, provided that the landlord concurs with the proposed modifications. The modifications to the apartment are as follows:

   List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work or common area work (such as handicapped parking spots or ramps not actually inside the rental unit).

2. The claimant agrees to occupy the apartment for the entire period of the lease as his or her residence and to obtain renter's insurance. The claimant will send proof of insurance to OWCP once renovations have been completed.

3. The claimant agrees to reside in the apartment for the length of the lease as noted above and to notify OWCP before any move which may result in a claim for new modifications.

4. The claimant agrees that the apartment may not be subleased to any other party or parties, and that the claimant has obtained signed written concurrence of the building management for these modifications, a copy of which is attached to this agreement.

_____ Date: _____
Claimant
CLAIMANT NAME

_____ Date: _____
Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Agreement Prepared By:

Name:
Title:
Date:

Memorandum of Agreement – Modification to Rental Property

(Office of Workers' Compensation Programs and Landlord)

LANDLORD'S WRITTEN CONCURRENCE TO THE PROPOSED MODIFICATIONS

I, **OWNER'S NAME**, the owner of **ADDRESS** consent to the physical modifications planned by **CLAIMANT** and his/her representative in order for **CLAIMANT** to live in the apartment. The initial length of the lease will be **#** years. I understand that these modifications to the apartment and common areas (and only these modifications) will be paid for by the Office of Workers' Compensation Programs as outlined below:

- **The items listed here should be the same as those provided on the claimant agreement.**

_____ Date: _____
Owner's signature
OWNER'S NAME
ADDRESS, WITH APT #

Agreement Prepared By:

Name:
Title:
Date:

2-1800-Exhibit 4 (Housing Modification)

Memorandum of Agreement – Housing Modification

(Office of Workers' Compensation Programs and Claimant)

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the modification of your primary residence, even though you are not the owner of said residence.

It is understood that you do not own the property at **ADDRESS**, but that you are living with a family member **(SPECIFY)** and plan to continue living at this residence. These housing modifications are therefore being approved based on the property owner's **(OWNER NAME)** agreement to provide housing to you on an ongoing and continuous basis and that the modifications in question are needed due to the limitations caused by your accepted work injury.

The undersigned agrees to the following:

1. OWCP will pay for modifications to the residence as detailed below, provided that the property owner concurs with the proposed modifications. The modifications to the residence are as follows:

   List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work, etc.

2. The claimant agrees to reside in this residence and to notify OWCP before any move which may result in a claim for new modifications.

_____ Date: _____
Claimant
CLAIMANT NAME

_____ Date: _____
Claimant's Representative (if applicable)
REPRESENTATIVE'S NAME

Agreement Prepared By:

Name:
Title:

Date:

Memorandum of Agreement – Housing Modification

(Office of Workers' Compensation Programs and Property Owner)

This agreement establishes the parameters under which the Office of Workers' Compensation Programs (OWCP) agrees to pay for the modification of **CLAIMANT's** primary residence at **ADDRESS**, owned by **(OWNER INFORMATION)**.

It is understood that **CLAIMANT** does not own the property at stated address, but that he or she is living with you and that you have agreed to provide housing to him or her on an ongoing and continuous basis. It is also understood that the modifications in question are needed due to the limitations caused by **CLAIMANT's** accepted work injury.

The undersigned agree to the following:

1. You agree to the renovations described below. OWCP will pay for these modifications, and only these modifications, as described in the attached document from **CONTRACTOR NAME**.

   List all approved modifications here. If necessary, list subcategories such as general construction, plumbing work, etc. The items listed here should be the same as those provided on the claimant agreement.

2. You will notify OWCP before any move which may result in a claim for a new house or a claim for modifications on a new house.

3. You agree that you will provide proof of adequate insurance, including home owner's insurance that reflects the value of your house, upon completion of the approved renovations. You will send proof of insurance to OWCP once renovations have been completed.

4. You must notify OWCP if you intend to relinquish your ownership of the house.

5. You understand that the Government is entitled to reimbursement for the value of the home modifications described in this agreement if the property is relinquished or the modifications are no longer needed if the value at that time exceeds $10,000. If the value is greater than $10,000 when relinquished or no longer needed, the amount of value above $10,000 must be reimbursed to the Department of Labor in a percentage of the total value based on the period of use. The Government agrees that the value of the home modifications will decrease at the rate of 10 percent of

the total per year. For example: If the home modifications are completed in December of 2009 and **CLAIMANT** resides in the house until December of 2015, the value of the renovations would have decreased by 60% in that time. The Government at that time would be entitled to reimbursement for 40% of the amount paid for the modifications. If **CLAIMANT** lives in the home and requires the modifications for 10 years, the Government is no longer entitled to any reimbursement amount. The government will not seek reimbursement of any amount until **CLAIMANT** no longer has need for the modifications.

I, **OWNER'S NAME**, the owner of **ADDRESS** consent to the physical modifications planned by **CLAIMANT** and his/her representative in order for **CLAIMANT** to live in this residence. I understand that only the modifications specified above will be paid for by the Office of Workers' Compensation Programs as outlined below:

By signing this agreement, all parties indicate an understanding of and agreement with the conditions set forth above regarding the housing modifications to be completed at **ADDRESS.**

_____ Date: _____
Owner's signature
OWNER'S NAME

_____ Date: _____
Co-owner(s) of the home (if applicable)
CO-OWNER'S NAME

Agreement Prepared By:

Name:
Title:
Date: