BCT-FY00

This infobase contains a numerical index of all **FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 2000**, as well as the text of these issuances.

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

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FECA BULLETIN NO. 00-01

Issue Date: November 5, 1999

Expiration Date: November 4, 2000

Subject: Medical--Use of Physicians Directory System (PDS)

Background: The PDS was originally developed to ensure that referee medical specialists would be chosen in a fair and unbiased manner, and this goal remains as vital as ever to the integrity of the Federal employees' compensation program.

Although the regulations do not impose the same rigorous requirements for second opinion medical examinations, it is the policy of the Office of Workers' Compensation Programs (OWCP) to ensure that such examinations be of the highest quality possible, and that the selection process for second opinion specialists be fair and well documented. Enhancements in the structure and use of the PDS will improve our ability to achieve those goals.

The PDS User Guide, which was published in 1991 and updated in 1993, was recently added to Folioviews as a new infobase. As it stands, this document is probably more useful from a systems viewpoint than for medical schedulers, and it does not explicitly address the role of the district office managers who are charged with overseeing the use of the PDS in their respective offices.

For these reasons, it seems desirable to provide policy guidance for managers and claims staff in addressing bypasses, additions and suspensions (previously termed "inactivations") from the system. Also, because several years have elapsed since the PDS was released and training was provided in its use, basic instruction in the use of the system for medical schedulers will shortly be provided in the form of an FECA circular.

Each district office's PDS database will soon be updated with current information (telephone numbers and addresses) for all physicians now active in the specialties previously included, as well as current information for physicians newly active in those specialties. The update will also contain listings of physicians in several new specialties and subspecialties. All specialties and subspecialties, including those newly added, are shown in Attachment 1.

On a one-time basis, the National Office will send form letters to all physicians whose PDS records are currently annotated "DOL-N" asking whether they are now willing to participate in the program. The results will allow the PDS Administrators to update their respective databases.

When the PDS User Guide is revised to include the material in this bulletin and its companion circular containing instructions for using the PDS, it will be reorganized to reflect the different responsibilities of medical schedulers, district office managers, and claims staff. Guidance for the PDS Administrator (usually the Systems Manager) will remain in its current form.

Reference: PDS User Guide; Federal (FECA) Procedure Manual, Chapter 3-500

Purpose: To provide guidance to district office personnel with respect to the use and maintenance of the PDS

Applicability: Claims Examiners, Senior Claims Examiners, All Claims Supervisors, Medical Schedulers, District Medical Directors, Technical Assistants, Systems Managers, Staff Nurses, and Vocational Rehabilitation Specialists

Action:

1. **Roles and Responsibilities**. The following individuals are responsible for the indicated actions in PDS:

a. *Medical Scheduler*. This individual is responsible for all entries in the PDS relating to scheduling specific medical appointments, including bypass codes and updating telephone and address records for physicians in the system. Only the medical scheduler(s) should select physicians; claims staff should not have access to the system.

b. *DO Manager*. This individual may be the District Director or designee, and contacts with physicians may be assigned to an in-house District Medical Director, at district office option. The DO Manager is responsible for evaluating complaints about specific physicians and problems with the quality and timeliness of their reports. He or she is also responsible for authorizing the addition and suspension of specific doctors. The DO Manager will have a password which will allow him or her to make these changes and also to designate a specific physician for a second opinion examination (but not for a referee examination).

c. *Claims Staff*. Claims Examiners (CEs) are responsible for ensuring that referee and second opinion medical specialists are chosen through PDS. They are also responsible for advising the DO Manager about medical reports which are of poor quality or very untimely, as well as complaints received from employees.

2. **Medical Scheduler**. The following guidance is intended to address various problems which may arise in scheduling referee and second opinion examinations.

a. *Alternate Zip Codes*. The zip code used should normally be that of the employee's home address, though the duty station may be used for good cause, for instance if the employee lives in a rural area and the duty station is located in an urban area with more physicians. Other zip codes should not be used unless:

(1) No physicians in the employee's zip code practice the necessary specialty. In this instance, PDS will select the closest neighboring zip code. Since zip codes are not always contiguous, it may be necessary to check a zip code map (available from the Postal Service) to find the neighboring zip code.

(2) The employee has requested an examination elsewhere. For instance, if the employee will be away from home temporarily, the zip code of the temporary location may be used.

b. *Bypass and Suspension Codes*. If a bypass code is used, the physician will be eliminated from consideration for a single rotation through the list. If a suspension code is used, the physician will no longer appear in rotation. While the Medical Scheduler may use bypass codes, the DO Manager must authorize any suspension from the PDS database, except for codes M, R, and P. (Suspension codes are shown in Attachment 2.)

If a physician states that he or she is not interested in taking cases from OWCP, the scheduler should ask why.

(1) If the answer reflects a short-term concern, the scheduler should find out when the physician will be able to accept cases from OWCP. For example, if the physician says he or she cannot take any new cases because the practice is totally booked and expected to be so for the next several months, a bypass code "B" should be used.

(2) If the answer reflects a more substantive concern, the scheduler should attempt to address the concern if possible. For example, physicians sometimes think that OWCP may ask them to defend their reports in court. Once they understand that this is not the case, the physician may agree to perform the examination.

However, if the physician clearly does not want to accept cases from OWCP, the medical scheduler should so advise the DO Manager, who can authorize use of the DOL "N" code to suspend the physician from rotation.

c. *Interaction with Claims Staff*. When an appointment has been scheduled, the medical scheduler should print a copy of the appointment screen and include it in the case file. A copy of this screen will need to appear in the case file.

Any request by a CE to select, or refrain from selecting, a particular physician should be referred to the DO Manager.

d. *Interaction with DO Manager*. The medical scheduler should inform the DO Manager of any unreasonably late reports. Also, any physician who asks the scheduler to be added to the PDS database (or other party who contacts the scheduler on a physician's behalf) should be advised to submit a copy of the physician's curriculum vitae (CV) to the DO Manager for consideration of inclusion in the system.

3. **District Office Manager**. With the new PDS database, the designated manager will need to be scrupulous about ensuring that the database is kept current.

a. *Adding a Physician*. The CV of any physician who expresses interest in being added to the PDS, or who is identified as appropriate by an OWCP nurse or other staff member, should be forwarded to the DO Manager, who will determine if the physician is board-certified in one of the acceptable specialties. (This must be verified with the State medical board, or with the American Board of Medical Specialties (ABMS), whose certification line can be reached at 800-776-2378 or at www.certifieddoctor.org.)

If the physician is board-certified, the DO Manager may authorize addition of the physician to the database, after ensuring (through use of the View or Browse function) that the physician is not already present on the database.

The DO Manager should retain all CVs received in an administrative file.

b. *Suspending a Physician*. A physician should seldom be suspended from the PDS, since bypass codes cover most situations. Only when the conduct of the physician is in question, or the quality and/or timeliness of his or her reports is at issue, should suspension be considered. The suspension codes are shown in Attachment 2.

Suspension from the PDS is very different from exclusion by regulation. A physician who is suspended from PDS will not be considered for referee and second opinion examinations, but may still continue to serve as an attending physician. A physician who is excluded from the program will be barred from receiving payment for any service to any employee.

c. *Canvassing "DOL-N" Physicians*. Periodically, the DO Manager will send a form letter asking all physicians in the DO's jurisdiction who have stated that they are unwilling to accept OWCP cases if they will reconsider their position in this matter. For those physicians who agree to accept OWCP cases, the DO Manager will authorize a change in the DOL flag from "N" to "Y".

d. *Poor Quality*. A physician can be suspended based upon the quality of his or her report. The DO Manager should review the documentation forwarded by the CE and decide whether suspension is proper.

If this is the first time such problems have occurred with this physician, the DO Manager should contact the physician and discuss the issues. The DO Manager should maintain an administrative file which documents the complaint and the discussion.

If more than one complaint has been received about the same physician, the DO Manager should decide if a pattern of unsatisfactory reports exists. If so, the physician should be suspended with a note indicating the reason and activate the "Completeness" flag in PDS.

e. *Lack of Timeliness*. A physician can also be suspended based on the timeliness of a report. The DO Manager should review the information forwarded by the medical scheduler with respect to any unreasonably late reports and decide whether suspension is proper.

For example, if a physician provides a report one month late on a complex case, the DO Manager may choose to document his or her administrative file but not to suspend the physician. On the other hand, if a physician takes several months to provide a report after many calls from OWCP, or provides no report at all, the DO Manager should suspend the physician and include a note citing the specifics of the incident.

f. *Other Complaints*. The DO Manager is responsible for reviewing all reports of other kinds of complaints, and for taking action if needed.

If a physician has performed multiple examinations before without reported problems, and the complaint does not appear

to be supported by the evidence in the case file, the DO Manager may choose not to act on the complaint.

By contrast, if another complaint has recently been lodged against this physician, and both complaints have been supported by the case files in question, the DO Manager should authorize the suspension of the physician with a note indicating the reason.

No minimum number of complaints need be lodged before suspension. One complaint, if severe enough, can be enough to suspend a physician. Copies of the complaints supporting suspension should be kept in an administrative file.

4. **Claims Staff**.

a. *Second Opinion Examinations*. District offices that use PDS for second opinion examinations must henceforth ensure that all such examinations are scheduled through PDS. As with referee medical examinations, the CE should indicate the type of specialty required. The CE should refrain from making a specific request to select or not to select a certain physician.

Ordinarily, the scheduler will attempt to make the appointment within 60 days. The CE should indicate any special time frame within which the examination is required.

b. *Copy of Appointment Screen*. When the medical scheduler has made the requested appointment (for either a referee or second opinion examination), he or she will run a copy of the appointment screen and drop it in the case file. This screen print must be placed in the case file to document that the physician who performed the examination was selected through PDS.

c. *Physicians Suggested by OWCP RNs*. OWCP field nurses occasionally suggest physicians who can perform evaluations. This practice may continue, with the understanding that the evaluation represents a consultation, and not an OWCP-directed second opinion examination. A physician suggested by an OWCP staff nurse may be added to the PDS (and therefore used for second opinion and referee examinations) if the physician's CV is obtained and the DO Manager agrees.

An employee who declines to attend an examination arranged by an OWCP nurse may not be sanctioned for failure to do so. Only refusals to attend OWCP-directed examinations may be sanctioned.

d. *Complaints*. All complaints must be made in writing. If the employee complains about the conduct of the physician during the examination, the CE should forward the complaint and copies of the report, the statement of accepted facts (SOAF), and the questions to the physician, to the DO Manager (through an intermediate supervisor, if any, at district office option). The DO Manager will review the complaint and take any action necessary.

e. *Poor Quality*. A report may be considered inadequate for any of several reasons, including failure to address the questions posed, failure to provide an opinion within the framework of the SOAF, and/or failure to provide a response to additional questions.

If such problems occur, the CE should work with the physician to obtain the necessary information. However, the CE should also advise the DO Manager that an inadequate report has been received (again, through an intermediate supervisor, if any, at district office option). The notification should include a copy of the medical referral letter, the SOAF and questions, and the medical report.

5. **Instruction and Evaluation**.

a. *Training*. All claims staff, medical schedulers, Staff Nurses, and District Medical Directors are to be trained in the procedures set forth above within 30 days of the date of this bulletin.

b. *Reports*. The National Office will develop new reports to evaluate compliance with the requirements set forth in this bulletin. These reports may be incorporated into the accountability review process.

Disposition: Retain until the indicated expiration date.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

Specialty/Subspecialty Codes
(The new specialties are shown in bold type.)

AI: Allergy and Immunization
AN: Anesthesiology
    PN: Pain Management
CR: Colon/Rectal Surgery
CV: Cardiovascular
DE: Dermatology
EM: Emergency Medicine
FP: Family Practice
GE: Gastroenterology
GS: General Surgery
HE: Hematology
HS: Hand Surgery
ID: Infectious Disease
IM: Internal Medicine
    SM: Sports Medicine
    ED: Endocrinology, Diabetes
MO: Medical Oncology
MT: Medical Toxicology
NE: Neurology
NM: Nuclear Medicine
NP: Nephrology
NS: Neurosurgery
OG: Obstetrics and Gynecology
OM: Occupational Medicine
OS: Orthopedic Surgery
OP: Ophthalmology
OT: Otolaryngology
PL: Plastic Surgery
PD: Pulmonary Disease
PM: Physical Medicine
PS: Psychiatry
    AP: Addiction Psychiatry
RA: Radiology
RH: Rheumatology
TS: Thoracic Surgery

UR: Urology
VS: Vascular Surgery

The specialties represented by the following new codes are used very rarely. To schedule an examination using one of them, contact Patricia Wood in the National Office at 202-693-0035.

CP: Clinical Pathology
- **CH: Chemical Pathology**
- **CY: Cytopathology**
- **MM: Medical Microbiology**
- **NU: Neuropathology**

PA: Anatomic Pathology

- **CH: Chemical Pathology**
- **CY: Cytopathology**
- **MM: Medical Microbiology**
- **NU: Neuropathology**

PR: Radiologic Physics

ATTACHMENT 2 - PDS DESK AID: Bypass Codes

B: The doctor can't give an appointment in a reasonable amount of time, or the doctor is on long vacation or leave of absence.

C: The physician (or his or her associate) was previously associated with the case, or the physician does fitness-for-duty exams for the employee's agency.

L: The physician is too far for the employee to travel.

M: The physician moved out of zip code area.

S: Need a different sub-specialty.

O: Other. (Requires a note explaining the reason.)

Use of codes B and O will result in the appearance of a notes window, with the prompt *Update DR Notes*.

Suspension Codes:

M: Physician moved out of district office's jurisdiction (to be used only when the physician's new address is unknown. Otherwise, the new address should be entered so that it can be made available to the new district office when the PDS database is next refreshed.)

R: Physician deceased or retired from practice

P: The physician's phone number is missing or wrong, and directory assistance cannot provide a better number.

E: Physician excluded under regulations or lost license

D: Duplicate of another record

T: Timeliness

Q: Quality

C: Complaint

F: Fee

O: Other

DOL "N": Physician definitely unwilling to take DOL cases.

FECA BULLETIN NO. 00-02

Issue Date: May 10, 2000

Expiration Date: May 9, 2001

Subject: Bill Payment/BPS - Bill Batch Numbers

Background: In the next several weeks, DFEC will be preparing to migrate from the Data General software that was previously used for bill batch scanning and the ECAB Pilot to the Kofax software that is used in OASIS (OWCP Automated System for Imaging Services) for bill batch scanning. Offices will use this new software for bill batch scanning well before most offices have OASIS for case files.

As part of this migration, DFEC must use a consistent structure for bill batch identification numbers, to enable proper storage of the bill batches, and retrieval by the users. In the past, each district office has developed its own bill batch numbering scheme. Under the new structure, while some customization is possible, certain elements must be consistent throughout all offices.

Reference: Federal (FECA) Procedure Manual Chapters 5.0200.10 and 5.0201.2.d(3).

Purpose: To communicate new requirements for bill batch numbering.

Applicability: All bill processing and imaging staff, including data entry, bill resolution, fiscal and mail room personnel.

Actions:

1. Effective May 15, 2000, bill batch numbering schemes and batch sizes must conform to the requirements as outlined in items 2 - 9 below. These requirements are applicable only to bills that are imaged. Bill batch numbers used for other purposes (such as adjustment input) need not follow the revised scheme.

2. The first two characters (numeric) will represent the District Office. This portion of the ID is used for the imaging system only, and is not part of batch number that is keyed into the FECS programs. These characters should be the same as the prefixes used for case file numbers (01 for Boston, 02 for New York, etc.)

3. The third character (numeric) will be the last digit of the current year. For the current

year, it will be 0 (zero).

4. The fourth character (alpha) will represent the current month, with A for January, B for February, etc., through L for December.

5. The fifth through eighth characters will be assigned by each district office. The office may choose to assign this portion of the batch number sequentially, or use it to designate other information, such as the type of batch, or the date of processing. For example, bill batches created in Jacksonville in March, 2000, could be assigned batch numbers as follows:

Imaging Batch ID	Bill Processing Batch ID
060C0001	0C0001
060C0002	0C0002
060C0003 etc.	0C0003 etc

6. The bill processing batch ID (third through eighth characters) is entered into FECS applications.

7. All one-sided bills should be scanned using simplex mode (one-sided scan only), to reduce costs. At a minimum, all HCFA-1500 and UB-92 bills should be scanned in simplex mode.

8. No bill batch should be larger than 50 pages. Bills scanned in simplex mode will count as one page each. Bills scanned in duplex mode will count as two pages for each sheet of paper, since both the front and back will be scanned.

9. From time to time, there is confusion between the number 0 (zero) and the letter O (oh), and between the number 1 (one) and the lower-case letter l (el). The letter O should not be used in a bill batch ID. All alpha characters should be upper case.

10. Further information concerning OASIS will be provided under separate cover.

Training on this Bulletin should be completed as soon as possible.

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

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

THIS SUPERCEDES BULLETIN 99-08, ISSUED JANUARY 4, 1999

FECA BULLENTIN NO.00-03

Issue Date: November 1, 1999

Expiration Date: November 1, 2000

Subject: New Regulations – Privacy Act

Background: FECA Bulletin No. 99-08, issued January 4, 1999, discussed new regulations involving the handling of requests submitted by FECA claimants under the Privacy Act. Paragraph five of that bulletin erroneously indicated that a claimant's access to his or her FECA claims file could be denied in only two situations. Additionally, paragraph six indicated, in error, that the 90-day appeal time did not begin to run until the requester received the denial letter. The 90-day period runs from the date of the denial. In light of these misstatements, the bulletin has been revised.

Reference: 20 CFR §§ 10.10 through 10.13 (1999); 29 CFR Part 71 effective December 1, 1998 (63 FR 56740 (October 22, 1998)).

Purpose: To inform OWCP staff, employing agencies and other interested parties of Privacy Act compliance requirements.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistance and Systems Personnel, and Hearing Representatives.

Action:

1. All records in OWCP claim files and all copies of records relating to an on-the-job injury that are in the possession of the employer are considered to be OWCP records covered by the Privacy Act system of Records DOL/GOVT-1. Although employing agencies may establish procedures employees must follow to obtain access to employer-maintained records, any decision to grant or deny access must comply with Department of Labor rules and regulations.

2. Under the amended regulations, only OWCP may respond to requests for the correction or amendment of any FECA-related record. Employing agencies must forward any

request they receive seeking to correct or amend such a record to OWCP.

3. The subject of a FECA file is entitled to receive the first copy of the file at no cost. The same rule would apply if the claimant requests copies of any documents not previously provided. OWCP or an employing agency may charge $.15 per page for each additional copy requested.

4. he filing of a request, or multiple requests, for more than one copy of a Privacy Act record will be viewed as an agreement by the requester to pay all applicable fees up to $25.00. When acknowledging a request, the disclosure officer should confirm this agreement by letter to the requester. The requester must be consulted before higher fees are assessed.

5. OWCP may require payment in advance of fees over $250.00. If such a fee is anticipated, a letter should be sent to the requester, noting the amount of the projected fee and advising the person that a designated staff person may be contacted to assist him or her in reformulating the request so that his or her needs may be met at a reduced cost.

6. OWCP may refuse to process any request submitted by an individual who has failed to pay an earlier fee, until the earlier fee is paid.

7. Any decision approving or denying a Privacy Act request must be in writing and signed by the designated Privacy Act disclosure officer. District Directors have been designated as OWCP disclosure officers. If copying of the requested documents will be delayed, an interim response should be sent indicating the reason for the delay and the date on which the documents will be mailed to the requester; this also should be under the signature of the disclosure officer.

8. As a general rule, the claimant may have access to each document in the claim file. There may be exceptions, however, such as where disclosure of medical records may be harmful to the individual. If there is question, the District Office should contact the appropriate regional office of the Solicitor of Labor to determine whether a document or documents may be exempt from disclosure. It should be noted that a request for access by the subject of the claim file shall not be denied unless both a Privacy Act exemption and a Freedom of Information Act exemption apply to the requested document(s).

9. If access to a particular record(s) is being denied, including those cases where OWCP is unable to find the requested record, the letter denying the request should include a statement of the reasons why access is being denied, and should cite to the specific statutory exemption applicable to the request.

10. When a request is denied, in whole or in part, the letter should advise the requester that he or she may, within 90 days of the date of the denial, file an appeal with the Solicitor of

Labor. The appeal must be in writing and addressed to the Solicitor of Labor, United States Department of Labor, 200 Constitution Avenue, N.W., Room N-2428, Washington, D.C. 20210-0002. The requester should also be told that both the letter and the envelope should be clearly marked "Privacy Act Appeal."

11. Even if the Disclosure Officer believes that all requested documents are being provided, the letter transmitting the documents should advise the requester that if he or she does not believe the letter to be fully responsive to the request, an appeal may be filed by writing to the Solicitor of Labor within 90 days of the decision. The letter should be sent to the address set forth in Item 10. Please no longer use the letter attached to FECA Bulletin 99-08.

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

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-04

Issue Date: November 19, 1999

Expiration Date: November 18, 2000

Subject: ADP - Formal Decisions/Concurrent Conditions

Background: The new imaging system, OWCP Automated System for Imaging Services (OASIS), will change the process by which case files are handled. The purpose of this system is to provide DFEC staff with an electronic case file to use in place of a paper file. Implementation of this system will have an impact on all phases of district office procedures for claims processed under OASIS. Since documents imaged under OASIS will be read-only files, no data entry will be permitted. Consequently, no CA-800 will be created for claims imaged through OASIS. While the FECS currently permits input of pay rate history, there was no automated tracking of concurrent medical conditions or formal decisions. Therefore, a new FECS screen has been developed to allow CE's to input concurrent conditions and formal decisions.

Purpose: This bulletin will provide guidelines for accessing and using the new Formal Decisions/Concurrent Conditions screen.

Applicability: Claims Examiners, Supervisors, System Managers, Technical Assistants, Rehabilitation Specialists and Staff Nurses.

Action:

Use of the Decisions/Concurrent Conditions screen is now mandatory. Concurrent conditions must be input for all newly created cases and all formal decisions issued after the date of this bulletin must be input. However, CA-800's will continue to be produced for non-imaged cases.

Accepted conditions for claims should be input into Case Management, Option #9 – Status/Accepted Conditions as is currently done. However, concurrent conditions must now be entered in Option #42 DECISIONS/CONCURRENT CONDITIONS of the Case Management menu. The F1 key permits a condition to be entered in text form. No ICD-9 coding is required. The F3 key permits modification of a line of text and the F5 key deletes a line of text. Instructions will appear at the bottom of the screen.

Any formal decision that is released must now be entered into Option #42 DECISIONS/CONCURRENT CONDITIONS. The F9 key permits toggling between the Case

Decision Update and the Concurrent Conditions Update portions of the screen.

The date a formal decision is released must be noted in the DECSN DATE field. This is a required entry with the format of MM/DD/YYYY.

Valid entries for the TYPE of decision will be displayed in a drop down menu as follows:

D = District Office
R = Reconsideration
H = Hearings and Review
E = ECAB)

An entry in this field is required.

Valid entries for the ISSUE field will also be displayed in a drop down menu as follows:

01-Time
02-Civil Employee
03-FOI-Factual
04-FOI-Medical
05-Causal Relationship/No Residuals
06-Continuing Injury Related Disability
07-POD
08-Recurrences
09-Schedule Award-Paid
10-Schedule Award-Denied
11-Overpayment
12-COP
13-LWEC – 0%
14-LWEC – Actual Earnings
15-LWEC - Constructed
16-Refusal/Obstruction of Medical Exam
17-Denial of Medical Treatment/Surgery
18-Failure to Accept Suitable Employment
19-Forfeiture
20-Non-cooperation with Rehab/Nurse Efforts
21-Recon Decision-Not Merit Review (ECAB decisions only)
22-Denial of Hearing
23-Recission
24-Third Party
25-Other

Again, an entry in the ISSUE field is required.

An entry in the DISP field is required. Valid entries will again appear in a drop down menu as follows:

D = Denied

A = Affirm
R = Remand
V = Reverse/Vacate
B = Affirm/Remand (affirmed in part and remanded in part)
N = Non-merit Review
C = Acceptance (adverse decision only)
M = Modified

The use of the same issue code, in conjunction with dates, will link an appeal decision to the appropriate adverse decision on a claim. For instance, a claim may be denied initially due to causal relationship and have a decision from Hearings and Review, several reconsiderations and a decision by the ECAB. The issue code would remain causal relationship as long as that is the decision being appealed.

An entry into both the EXAM and CERT fields is required. Both the examiner and the certifier will use the location code assigned to them by their district office.

No entry is required in the EXAMINIT or CERTINIT fields. Use of examiner's initials and certifier's initials fields will be at the discretion of the district office.

New query options have also been added to Case Management and Query. Case Management Option #43 - Query Decisions/Concurrent Conditions, and Query Option #11 – Decisions/Concurrent Conditions will display all concurrent conditions and formal decisions for a particular file number. In addition, the Reported Accepted Conditions portion will display all accepted conditions for the particular case queried as well as conditions for any other cases in the database with the same SSN. This would include cases that have been denied, accepted or administratively closed.

This information will also be available from the Auto 110 menu in the near future.

Examples: A claim is initially denied as FOI (factual) on September 1, 1999. The claimant requests reconsideration of this decision on October 1, 2000. The SrCE denies the request for reconsideration as not timely filed on November 10, 2000. The initial decision would have a type code of D (district office), an issue code of 03 (FOI-factual) and a disposition code of D (denied). The second decision would have a type code of R (reconsideration), an issue code of 03 (FOI-factual) and a disposition code of N (non-merit review).

A claim is initially denied as FOI (medical) on September 2, 1999. On September 3, 1999, the CE receives the necessary medical evidence and realizes the evidence was received in the office on September 1, 1999. On September 3, 1999 the CE vacates the September 2, 1999, decision and accepts the claim. The initial denial of the claim would have a type code of D (district office), an issue code of 04 (FOI-medical) and a disposition code of D (denied). On the date the initial decision is vacated and the claim accepted, the type code would be D (district

office), the issue code would be 04 (FOI-medical) and the disposition code would be R (reverse/vacate).

Disposition: Retain until the expiration date or until superseded.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-05

Issue Date: June 8, 2000

Expiration Date: June 7, 2001

Subject: Comp Pay--Extra Pay for Firefighters

Background: In 1989, OWCP determined that pay rates for COP and compensation would properly include extra pay authorized under the Fair Labor Standards Act, 29 U.S.C. 207(k), for firefighters, emergency medical technicians, and other employees who earned and used leave on the basis of their entire tour of duty, and who were required to work more than 106 hours per pay period. This policy was first addressed in FECA Bulletin 89-26, and it now appears in FECA Procedure Manual Chapter 2-900, paragraphs 7b(21) and 8c.

However, Public Law No. 105-277 amended Title 5 of the U. S. Code to define hours worked by firefighters in excess of 106 biweekly, or 53 weekly, as overtime. It also states that firefighters shall not receive premium pay authorized by other provisions of subchapter V of chapter 55 of Title 5. The effective date of this provision was the first day of the first pay period after October 1, 1998, which was October 11, 1998.

Section 5 U.S.C. 8114(e) of the FECA bars inclusion of overtime pay in pay rates for compensation purposes. As the extra pay earned by firefighters is now classified as overtime, this rule will therefore apply to these employees as of October 11, 1998. Firefighters with pay rate effective dates on or after that date are not entitled to receive the "extra pay" discussed in PM 2-900.7b(21) and 8c (either "FLSA OT" or "standby premium pay").

Public Law No. 105-277 also provided that certain firefighters would be entitled to an increase in basic pay equal to two step increases of the employee's grade at the time the law took effect.

Finally, although PM 2-900.7b(21) refers to Emergency Medical Technicians (EMTs) and other employees with similar schedules, Public Law No. 105-277 applies only to firefighters.

Reference: FECA Bulletin 89-26; FECA Procedure Manual Chapter 2-900.7b(21) and 8c.

Purpose: To advise claims staff of the provisions of Public Law No. 105-277 as they apply to the pay rates of firefighters.

Applicability: Claims Examiners, Senior Claims Examiners, Claims Supervisors, Fiscal Officers, Technical Assistants, Hearing Representatives, and Hearing Examiners

Action:

1. The procedures that follow apply only to firefighters who earned and used leave on the basis of their entire tour of duty, and who were required to work more than 106 hours per pay period. Some firefighters work fewer hours per pay period, and because their pay rates should never have included the extra increments which are the subject of this bulletin, no adjustments are needed.

2. For firefighters with pay rate effective dates (whether date of injury, date of recurrence, or date disability began) from July 21, 1987 to October 10, 1998, "FLSA extra pay" and standby premium pay should still be included in the pay rates. The calculation of these increments is described in PM 2-900.8c.

3. For firefighters with pay rate effective dates on or after October 11, 1998, "FLSA extra pay" and standby premium pay may no longer be included in pay rates. While firefighters may well work more than 106 hours per pay period, the annual or biweekly rate of pay provided by employing agencies should not include overtime.

4. Hourly rates of pay may be derived by dividing the annual rate of pay by 2756 (the number of hours in a work year for these employees, analogous to the figure of 2087 hours used for regular federal employees). The rate of pay per pay period may be obtained by multiplying the hourly rate by 106. (Or, the rate of pay per pay period may be obtained by dividing the annual rate by 26.)

5. When making loss of wage-earning capacity determinations, the step increases granted by Public Law No. 105-277 should not be considered in calculating the current pay for grade and step when injured. Rather, the original grade and step should govern the figure used.

6. District office managers will be advised by memorandum of any cases in their respective jurisdictions for firefighters (occupation code G0081) with pay rate effective dates on or after October 11, 1998. These cases must be examined to determine if the pay rates are accurate, and if not, the pay rates must be adjusted.

Disposition: Retain until the indicated expiration date.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

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

FECA BULLETIN NO. 00-06

Issue Date: December 27, 1999

Expiration Date: December 27, 2000

Subject: Debt Collection: Perpetual Debts

Background: A recent audit by the Office of Inspector General has noted that, despite efforts to review all debts and forward all required debts to the Treasury Department for collection activity, there is another universe of debts which, although not delinquent, are not being adequately collected.

Specifically, these have been termed "perpetual debts" because, often, there are regular payments (or a payment plan) which are not adequate to meet accruing interest, hence the debt is not being reduced although it is also not showing as overdue.

It is necessary that district office staff begin taking action to review these debts and, where necessary, take action to resolve the perpetual debt status.

Purpose: To inform District Offices of the need to evaluate perpetual debts for either Treasury referral or compromise.

Reference: FECA Bulletin 98-06; FECA PM Ch.6-300

Applicability: All Claims and Fiscal staff.

Action:

1. All District Offices must take action to review all debts to locate any on which regular payments are being received over an extended period but where the payments are inadequate to pay down the debt balance in a reasonable period.

2. Any debt identified as a perpetual debt must be evaluated and either

(a) compromised to limit the repayment period (this would include waiver of charges

if not previously considered); or

(b) referred to National Office for referral to Treasury per procedures outlined in FECA Bulletin 98-06; or

(c) referred to National Office for referral to the Department of Justice for compromise if the debt is more than $100,000 (or more than $600 when fraud is involved).

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

DENNIS M. MANKIN
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-07

Corrected Copy

Issue Date: January 3, 2000

Expiration Date: January 2, 2001

Subject: Compensation Pay: Compensation Rate Changes Effective January 2000.

Background: The new GS-15, Step 10, salary was shown incorrectly in the original Bulletin. ***This Bulletin reflects the correct salary for GS-15, Step 10.*** In December 1999, the President signed an Executive Order implementing a salary increase of 3.80 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only applies to the 3.80 percent increase in the basic General Schedule. Any additional increase for locality-based pay is excluded. The adjustment is effective the first pay period after January 1, 2000.

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

The new rates will be effective with the first compensation payroll period beginning on or after January 1, 2000. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $100,897 per annum.

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

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

Effective January 2, 2000	Minimum	Maximum
Monthly	$ 1,299.50	$6,306.06
Weekly	224.91	1,455.25
Daily(5-day week)	44.98	291.05

The basis for the minimum compensation rates is the salary of $15,594 per annum (GS-2, Step 1) and the basis for the maximum compensation rates is $100,897 per annum (GS-15, Step 10).

The effect on 5 U.S.C. 8133(e) is to increase the minimum monthly pay on which compensation

for death is computed to $1,299.50, effective January 2, 2000. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $6,306.06 per month.

Applicability: Appropriate National and District Office personnel.

Reference: Memorandum For Directors of Personnel dated December 1999; and the attachment for the 1999 General Schedule.

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

1. Adjustments Dates.

a. As the effective date of the adjustment is January 2, 2000, there will be no supplemental payroll necessary for the periodic disability and death payrolls.

b. The new minimum/maximum compensation rates will be available in ACPS on or about January 21, 2000.

2. Adjustment of Daily Roll Payments. Since the salary adjustments are not retroactive, it is assumed that all Federal agencies will have ample time to receive and report the new pay rates on claims for compensation filed on or after January 1, 2000. Therefore, it will not be necessary to review any daily roll payments unless an inquiry is received. If an inquiry is received, verification of the pay rate must be secured from the employing establishment.

3. Minimum and Maximum Adjustment Listings. Form CA-842, Minimum Compensation Pay Rates, and Form CA-843, Maximum Compensation Rates, should be annotated with the new rate information as follows:

CA-842

1/02/00	44.98-67.47	224.91-337.37	44.98	224.91	1,299.50
	44.98-59.97	224.91-299.88			

CA-843

1/02/00	291.05	1,455.25	(5,821.00)	6,306.06

4. Forms. CP-150, Minimum/Maximum Compensation, will be generated for each case adjusted. It should be noted that this adjustment process re-calculates

EVERY ACPS record from very beginning to current date, thus, it may be that minor changes in the gross compensation are noted; this is not necessarily incorrect. Notices to payees receiving an adjustment in their compensation will be sent from the National Office. Form CA-839, Notice of Increase in Compensation Award, will be utilized for this purpose. Manual adjustments necessary because of gross overrides should be made on Forms CA-24 or CA-25 with a notice sent to the payee by the District Office.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-09

Issue Date: March 1, 2000

Expiration Date: February 28, 2001

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 2000.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 2000.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 2.7 percent.

2. The increase is effective March 1, 2000, and is applicable where disability or death occurred before March 1, 1999.

3. The new base month is December 1999.

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

   $ 6,306.06 per month
   1,455.25 per week
   5,821.00 each four weeks
   291.05 per day (for a 5-day week)

Applicability: Appropriate National Office and District Office personnel.

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

Action: On or about March 17, 2000, both the periodic disability and death payrolls will be updated in ACPS. If there are any cases with gross overrides, there will be no supplemental record created. Thus, the cases with gross overrides must be reviewed to determine if CPI adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustment Dates.

   a. As the effective date of the CPI is March 1, 2000 and the start date of the periodic and death payroll cycles is February 27, 2000, there will be a

supplemental record created for the period March 1 through March 25, 2000. Effective March 26, 2000, the periodic and death payrolls will reflect the increased amount.

b. The CA-816, LWEC, program will be updated with the new CPI percentage. This update will be performed for all district offices by the National Office.

2. Adjustments of Daily Roll Payments. Since the CPI will not be in ACPS until March 20, 2000, daily roll payment cases requiring the new CPI should be held for data entry until that date. *ACPS RECORDS THAT REQUIRE ADJUSTMENT SHOULD NOT BE ENTERED BETWEEN MARCH 17, 2000 AND MARCH 20, 2000.* ACPS data entry may resume on March 21, 2000.

3. CPI, Minimum and Maximum Adjustments Listings. Form CA-841, Cost-of-Living Adjustments; Form CA-842, Minimum Compensation Rates; and Form CA-843, Maximum Compensation Rates, should be updated with the new information. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966 through March 1, 2000.

4. Forms.

a. Beginning with the compensation payment cycle that covers March 26, 2000 to April 22, 2000, the Office will issue a monthly Benefit Statement to each individual receiving benefits on the 28-day periodic roll cycle. This Benefit Statement will state the gross amount of compensation, the period of compensation covered by the statement, and the pertinent deductions made from the gross compensation. For compensation payments made via paper checks, the Benefit Statement will accompany the check. For compensation payments made through Electronic Fund Transfer (EFT), the Benefit Statement will be mailed separately.

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

c. A CP-140 report will be printed for each case adjusted, upon specific request by a District Office.

d. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification; insurance verification; loan application; etc.), please provide this data in letter form from the district office. Many times a benefit statement may not reach the addressee, and regeneration of the form is not

possible. Thus, a simple letter indicating the amount of compensation paid every four weeks will be an adequate substitute for this purpose.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

Attachment

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

ATTACHMENT - Cost of Living Adjustments

COST-OF-LIVING ADJUSTMENTS
Under 5 USC 8146(a)

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	09/01/80	4.0%
01/01/68	3.7%	03/01/81	3.6%
12/01/68	4.0%	03/01/82	8.7%
09/01/69	4.4%	03/01/83	3.9%
06/01/70	4.4%	03/01/84	3.3%
03/01/71	4.0%	03/01/85	3.5%
05/01/72	3.9%	03/01/87	0.7%
06/01/73	4.8%	03/01/88	4.5%
01/01/74	5.2%	03/01/89	4.4%
07/01/74	5.3%	03/01/90	4.5%
11/01/74	6.3%	03/01/91	6.1%
06/01/75	4.1%	03/01/92	2.8%
01/01/76	4.4%	03/01/93	2.9%
11/01/76	4.2%	03/01/94	2.5%
07/01/77	4.9%	03/01/95	2.7%
05/01/78	5.3%	03/01/96	2.5%

11/01/78	4.9%	03/01/97	3.3%
05/01/79	5.5%	03/01/98	1.5%
10/01/79	5.6%	03/01/99	1.6%
04/01/80	7.2%	03/01/00	2.7%

Prior to 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 "periodic" basis or the nearest $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).

Prior to 11/1/74	Eff. 11/1/74
.08-.34 = .23	.13-.37 = .25
.35-.57 = .46	.38-.62 = .50
.58-.80 = .69	.63-.87 = .75
.81-.07 = .92	.88-.12 = 1.00

FECA BULLETIN NO. 00-10

Issue Date: February 1, 2000

Expiration Date: January 31, 2001

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

Background: Effective January 14, 2000, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobiles is increased to 32.5 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, determination has been made to apply the applicable rate to disabled FECA beneficiaries traveling to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

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

Action: Instruction CA-77, Instructions for Submitting Travel Vouchers, has been revised to reflect the indicated rate change. A copy of the revised instructions is attached to this bulletin and may be reproduced at local levels. It will not be necessary to search and locate vouchers processed subsequent to February 1, 2000; however, if inquiry is received, appropriate adjustment should be made. Vouchers being processed for travel periods after February 1, 2000, may be adjusted to reflect this increase.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

Attachment

Distribution: List No. 2 -- Folioviews Groups A and D

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

ATTACHMENT - Form CA-77

Instructions for Submitting Travel Vouchers (For reimbursement of travel and related expenses Under the Federal Employees' Compensation Act)	U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs

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Note: Any item not in conformity with the following instructions and not legible will be deducted from the voucher. **Both forms SF-1012 and SF-1012a *MUST* be submitted with a valid case file number**.

Claim for necessary and reasonable expense incident to travel authorized in accordance with provisions of the Federal Employees Compensation Act may be submitted for consideration on Voucher Forms SF-1012 and SF-1012a. Travel must be by shortest route and, if practicable, by public conveyance (streetcar, bus, boat, or train).

The Office will promptly reimburse all bills received on the approved form and submitted in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the calendar year in which the claim was first accepted as compensable by the Office, whichever is later (per CFR §10.413).

Payment will be made for taxicab fare or the hire of special conveyance where streetcars, buses, or other public and regular means of transportation are not available, except where these cannot be used because of the injured employee's disability. If claim is made for payment of expenses for taxicabs or hire of special conveyances, a full explanation must be made showing the necessity thereof.

Reimbursement for transportation by automobile owned by an employee or a member of his/her immediate family or another Government employee, may be claimed when no public conveyance is available or where the physical condition of the injured employee requires the use of special conveyance.

Mileage expenses will be reimbursed at the following rates for travel during the following periods:

Period	Rate
January 1, 1995 - June 6, 1996	30 cents per mile
June 7, 1996 – September 7, 1998	31 cents per mile
September 8, 1998 – March 31, 1999	32.5 cents per mile
April 1, 1999 – January 13, 2000	31 cents per mile
January 14, 2000 - and after	32.5 cents per mile

If mileage expense is claimed prior to January 1, 1995, contact your OWCP district office for rates.

Claim may be made for parking fees. If travel must be over a toll route, toll charges may be claimed. The voucher must show the locations where travel began and ended, mode of travel, and name of the transportation company (if by public conveyance). List each item of expense separately, showing the date incurred, place, and cost of the travel.

There will be no reimbursement for meals or lodging when travel is for less than 12 hours in total. If the authorized travel was for longer than 12 hours, and a claim for meals or lodging is made, the dates and hours must be shown on the voucher. The necessity for lodging must be explained in detail. All charges must be reasonable, and will be reimbursed at the per diem rate for the locality of travel.

Any stopover or delay en route should be carefully explained. If several trips are covered by the same voucher, list each separately, indicate the purpose of each trip, and secure the approval of the attending physician, certifying that the dates are correct according to his/her records.

Original itemized receipts made out in factor of the person making payment, signed in ink or indelible pencil by the person receiving payment must be furnished for all items in excess of $75.00.

After a voucher SF-1012 has been completed, it must be signed in ink or indelible pencil in the space provided for the payee.

The travel voucher should not be submitted if there is no expense claimed.

INSTRUCTION CA-77
Revised January 2000

FECA BULLETIN NO. 00-11

Issue Date: February 25, 2000

Expiration Date: February 24, 2001

Subject: Bill Payment/BPS - Correct Coding Initiative, Part B.

Background: In August of 1999, Part A of OWCP's Correct Coding Initiative (CCI) was implemented. Since that time, coding specialists have been hired in each district office, and training has been provided to them.

Effective on or about February 25, 2000, Part B of the CCI will be implemented. Part B contains editing for mutually exclusive procedures, comprehensive/component procedures, and add-on codes. Editing for global periods will be implemented at a later date.

The source for the mutually exclusive and comprehensive/component code pairs is HCFA (Health Care Financing Administration). This information is updated quarterly. The source for the add-on codes is the AMA CPT Coding Manual. This information will be updated annually.

Mutually exclusive procedures are defined as procedure code pairs for which there is a medical impossibility or improbability that they would be performed at the same session. An example of mutually exclusive procedures is code 27332 (arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial or lateral) and code 27310 (arthrotomy, knee, with exploration, drainage, or removal of foreign body).

Comprehensive/component procedures are code pairs for which a more comprehensive procedure code includes several procedures that also have individual component procedure codes. Providers are not allowed to bill separately for a comprehensive code and the related component codes. An example of this type of coding error would be using component code 97750 (physical performance test or measurement, with written report, each 15 minutes) with comprehensive code 97003 (occupational therapy evaluation).

Add-on codes are procedures that are carried out in addition to the primary procedure performed. The add-on codes can never be reported alone. The add-on codes are listed in Appendix E of the CPT Coding Manual. An example of an add-on code is code 22632 (each additional interspace), which must be used with code 22630 (arthrodesis, posterior interbody technique, single interspace, lumbar).

At approximately the same time that the CCI Part B edits are installed, the edit for unlisted procedures (edit 364) will be activated. Information concerning this edit was provided previously, and additional information is being provided to the coding specialists under separate cover.

Reference: Federal (FECA) Procedure Manual Chapters 5-0203 and 5-0204; FECA Bulletin No. 99-29, issued August 5, 1999.

Purpose: To communicate procedures for processing bills under the CCI, Part B.

Applicability: Claims Examining, Bill Processing and CCI personnel.

Actions:

The CCI edits are applicable only to certain CPT-4 and HCPCS codes.

For some mutually exclusive and comprehensive/component code pairs, a procedure code modifier may be used to indicate that the procedures are not truly mutually exclusive or comprehensive/component. However, a modifier does not have this effect for all code pairs. The data provided by HCFA includes a modifier indicator, which is being used by the system in the CCI edits. It is critical that modifiers present on the bill be data entered when the bills are keyed. There are several additional modifiers that have recently been added to the system. Currently, all of the modifiers listed on the inside front cover of the CPT 2000 coding book are valid in the FECS system.

Seven new edits have been developed for CCI Part B. These include edits for mutually exclusive codes (edits 372 and 373), comprehensive/component codes (edits 374, 375, and 377), and add-on codes (370 and 371). Detailed edit sheets for these seven new edits are being sent under separate cover, along with the revised condensed BPS edits, and the revised EOB listing.

When errors 370, 372, and 374 are assigned, denial is automatic, and the edit failure cannot be overridden. Edit 371, 373, 375, and 377 failures result in suspensions, which must be manually reviewed and may be overridden or set to deny as appropriate.

All billing issues with respect to these edit failures, including resolution of these edit failures, should be referred to the coding specialist. The coding specialist is not responsible for other edit failures that may occur on a bill. Other edit failures on the bill should, in general, be resolved before the bill is referred to the coding specialist.

To assist in resolving CCI edit failures, and to provide information on the outcomes of the CCI editing, a "CCI Edit Report" will be produced each time BILL552 is run. This report should be provided to the coding specialist.

Job aids for resolving these new CCI edits will be provided to the coding specialists under separate cover.

Training on this Bulletin should be completed within 30 days of the issuance of this bulletin.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-12

Issue Date: March 15, 2000

Expiration Date: March 15, 2001

Subject: Automated CA-110, Telephone Message

Background: In November of 1994, the automated CA-110 program was created to address the Program's lack of a comprehensive telephone call tracking system as well as various communication concerns.

The use of the automated form has become widespread, and use of the data on these forms has been helpful both on a District Office and National Office level to address ongoing communication concerns. A current such concern is the level of service given to requests for authorization for physical therapy and other medical services. In light of this, the current automated CA-110 has been enhanced to include additional codes to address the level of response given when a request is telephonic. This will allow offices (as well as the National Office) to track level of responsiveness and to assure that all authorizations which are sought are answered timely.

Reference: FECA Bulletin 95-2

Purpose: To outline and provide guidance for the use of enhancements to the automated CA-110.

Applicability: All District Office and National Office personnel who use CA-110 forms to record and track responses to telephone messages.

Action:

1. When any telephone call is received that addresses an authorization for a medical service or procedure (including requests for physical therapy), an automated CA-110 should be used. This is true whether authorization is given immediately (therefore requiring no further response) or whether further communication is necessary. This procedure does not differ from that outlined in FECA Bulletin 95-2.

2. The PTA and OMA codes now in existence for physical therapy and other medical authorizations are now to be used only by a person initially taking a telephone call, whether in a contact office or off of the voice mail system. Any response where the caller actually speaks to a claims examiner concerning the authorization should use one of the new

codes outlined in item 3.

3. There are now six new codes available to indicate the level of response to an inquiry for physical therapy or other medical authorization. These codes should be used to specify the type of answer given to any authorization request. They are:

PTAI - Physical Therapy Authorization, Interim
PTAS - Physical Therapy Authorization, Substantive
PTAF - Physical Therapy Authorization, Final
OMAI-Other Medical Authorization, Interim
OMAS- Other Medical Authorization, Substantive
OMAF- Other Medical Authorization, Final

"Interim" should be used if the telephone call was answered, but the authorization sought was not yet granted or denied; generally this will be the case if more information is necessary prior to a decision and if the response given to the person contacting the office is brief. In such an instance, a response in further depth will be required, whether telephonically or in writing.

"Substantive" is the appropriate status if the caller was advised of some indication of the current status of the case, but an answer on the authorization remains unavailable. An example of this is a surgery request, where a second opinion has been scheduled to address the issue. Advising a caller of the appointment's existence and date would be sufficient to make the response substantive.

"Final" should only be used if the authorization sought was given or denied during the telephone call. Note that any decision on authorization should be appropriately documented in the case file and in the FECS.

4. While coding in the automated CA-110 will address the level of response to a request for authorization, the actual data concerning the period of any such authorization should be recorded as appropriate in other FECS applications--that is, authorization for physical therapy should be recorded in Case Management item 34, and any other authorization should be the subject of a Case Management note and, possibly, the addition of an ICD-9 procedure code.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-13

Issue Date: March 27, 2000

Expiration Date: March 27, 2001

Subject: Reporting Injuries--Electronic Submission of Forms CA-1 and CA-2

Background: As efforts continue to streamline the adjudication and case management process, employing agencies have sought the ability to submit initial claim forms electronically, eliminating the mailing lag time that is occasionally involved with paper submissions.

Agreements are now in place for this to happen, and programming allowing this type of submission is complete. Shortly, employing agencies will begin to submit batches of forms CA-1 and CA-2 electronically. The first agency to do so will be Veterans Affairs(VA), which will submit both their own claims and, in the future, claims as a batching representative for other agencies, forwarding claims from various smaller employers. It is anticipated that both the Department of Defense and U.S. Postal Service will follow soon thereafter.

Purpose: To inform all DFEC staff of the impending submission of initial claim forms electronically.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants, Systems Personnel, and Hearing Representatives.

Action:

1. Batching agencies (such as the VA) will submit a daily batch of new claim forms for all employing agencies they represent. This batch will be submitted electronically to the Branch of Coordination and Control in the National Office (NO). The files will be retrieved in NO Sequent and placed in a directory accessible to DFEC. They will then be archived (to retain a record of information submitted), assigned a batch number (typically the agency identification and a date), and then copied to a working directory.

2. The files will then be translated electronically and edited to ensure that they are in the proper format and contain all required information. Any errors will be noted via electronic communication to the submitting agency.

3. All properly submitted and translated files are then placed in a directory on the Sequent,

sorted by District Office, in fixed format. All information received is then added to an NO cross-reference table which will be used to track the case number assigned by the DO. The employing agencies submitting information in this fashion will retain the paper claim forms supporting the electronic data submitted.

4. The files are then transmitted to the DO and the data is placed into CA-1 and CA-2 database files in the DO. Each DO should set up an e-mail list so that a report, created when the files are received in the DO, may be e-mailed notifying DO management of the receipt of a new batch. This group should be created on the DO level and entitled "**DO Name** CA-1/2 Group." Included should be the Regional Director, District Director, Systems Manager, Case Create Supervisor (if different from Systems Manager), and William Cole, Chief, Branch of Coordination and Control. Case files must be created within 48 hours of receipt of this e-mail.

5. The case create staff will then review electronic CA-1 or CA-2 forms online. The screen on which this will be done approximates the current paper CA-1 or CA-2. It can be accessed as a sub-menu to item 01 in Case Management on Sequent.

6. After the claim form is reviewed, a case number will be assigned by the case create clerk just as if a paper form were received. When the case number is entered, the system will automatically add the case to case management and pull all necessary info from the electronic form without the need for further keying. The postcards generated via current case create procedures will also be run automatically.

7. The electronic CA-1 or CA-2 will be printed and placed into the paper file (in offices not yet using the OASIS system). This screen print does not, currently, approximate the paper form CA-1 or CA-2 in format, although all of the information it contains is identical. The system is being enhanced so that the printout, will, eventually, mimic the paper forms in style and format.

If a DO is currently imaging new files, the electronic CA-1 or CA-2 will be printed and scanned into OASIS so it may be reviewed onscreen along with all other case documents. Case files will be routed to claims examiners in the same manner as those created from paper claim forms. Claims examiners will also be able to access a sequent query screen (query item 13) showing the online claim form for both imaged and non-imaged cases should they so choose.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-14

Issue Date: April 12, 2000

Expiration Date: April 11, 2001

Subject: Compensation Payment - Change of Address in ACPS and CMF

Background: Recent OIG audit findings indicate a need to modify the process of changing addresses in ACPS and CMF to ensure that adequate separation of duties exists. It has been demonstrated that such separation is necessary, not only for the effective processing of compensation payments, but also for the security of our mission and accountability of OWCP in disbursing monies from the Compensation Fund.

Reference: FECA Procedure Manual Chapter 2-401.3a, and Chapter 5-308.5n. and 5o.

Purpose: To emphasize the importance of separation of duties between the personnel who receive the written request for an address change and initiate action to make the change in the ACPS or CMF, and the personnel who verify and enter the change for the purpose of directing compensation payments. In addition, to provide procedures for all FEC offices and to ensure that personnel affected by these procedures know how to implement them.

Applicability: Regional Directors, District Directors, Fiscal Officers, Bill Payment Supervisors, Claims personnel, and appropriate National Office personnel.

Actions: Satisfactory procedures for handling changes of address in the CMF and ACPS include several elements described as follows:

1. The action to change an address must be initiated by the claimant/payee or authorized representative in written form. A telephone contact is not sufficient to cause OWCP to change an address.

2. No person with ACPS access will be involved in the process of changing addresses for directing compensation payments. This includes address changes for checks and EFT account information. Both the person who enters the change of address into the system and the person who verifies it will be non-claims personnel. That is, they are not to have access to any other claims payment options in the ACPS menu. Each District Office will designate the appropriate staff person(s), and the list of such persons will be maintained in the District Director's office. The District Director's list will be updated immediately

as changes in this responsibility occur.

3. The source document for the address change must be signed by the claimant/payee or the authorized representative. A typical example of a source document would be a letter from the claimant/payee or representative. Another common document for this purpose would be a standard form such as the SF-1199a, which is used to switch from receiving the mailed check at the home address to receiving payment by EFT (electronic funds transfer), where the compensation payment is deposited directly into the claimant's bank account from Treasury. An existing EFT address (bank account number or routing number) should be changed in ACPS with a signed SF-1199a form or a similar form generated by the financial institution and signed by an institution official. We strongly encourage the use of the SF-1199a; however, any official bank document is acceptable so long as it is accompanied by the original signature of the claimant.

4. The person initiating the change of address action and the non-claims person entering the change into ACPS must initial and date the input documents. The person who completes the action by verifying the accuracy of the change on the output document (also a non-claims person) must initial and date the output document. With all changes of address, the payment must be treated as an initial payment, and as such must be certified by a person qualified to certify payments.

5. All ACPS payment inputs requiring certification must be documented with the following:

> Source documents (i.e., a letter from the claimant/representative, CA-7, or SF-1199a).
> Input documents (CA-25, screen prints, etc.)
> All output documents (e.g., CP-030, CP-040, CP-045, CP-230, CP-285).

Source documents must be present for any certified input. For any EFT changes, such as in routing or account number, the source document must be either an SF-1199a or a similar form. Any form must include information provided by the bank and must be signed by the claimant/representative and, preferably, by an official of the financial institution.

Whoever pulls and distributes outputs must assure that outputs are delivered to a single person designated by management in each unit/area. This person will then assure that all outputs are properly distributed.

The source document, input document and output document, once certified/verified, must be stapled or spindled together in the case file. All such documents must be retained, and no output document may be discarded.

6. If your District Office currently has satisfactory procedures in place for processing changes of address in the ACPS and CMF (which adhere to all of the stipulations described above), they should be continued.

7. District Office managers must ensure that all affected personnel are aware of this process and recognize its importance. Adherence to these procedures will be monitored biannually in the accountability review process and annually during the OIG's Consolidated Financial Statement Audit.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual Chapter 2-401 and Chapter 5-308.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 00-15
AMENDED

Issue Date: September 18, 2000

Expiration Date: September 17, 2001

Subject: COP Nurse Intervention

Background: The President's Federal Worker 2000 initiative directs the Secretary of Labor to reduce the overall occurrence of injuries by 3 percent per year, while improving the timeliness of reporting of injuries and illnesses by agencies to the Department of Labor by 5 percent per year, reduce the occurrence of such injuries by 10 percent per year for those work sites with the highest rates of serious injuries and reduce the rate of lost production days by 2 percent per year.

In order to meet these goals, OWCP has placed strategic emphasis on prompt adjudication and payment of benefits, early intervention in new injuries, active disability management and prompt, appropriate return to the workplace. It is felt that early intervention during the Continuation of Pay (COP) period will have a favorable impact on these goals by permitting early identification of injuries that may result in additional lost time after the COP period.

To this end, OWCP is implementing a nurse intervention program during the COP period that will be solely telephonic in nature and will be limited to thirty days of case management. Such early intervention depends on prompt submission of claim forms by employing agencies, since any cases with an initial work stoppage date more than thirty days prior to the date the case is received by OWCP will not be considered for this program.

Although nurse intervention will not be extensive during the COP period, the nurses' medical knowledge and experience will permit them to identify cases that will require more extensive nurse intervention due to the severity of the injuries, contemplated surgical intervention, or other such issues. They will also be able to discuss injured workers' medical concerns and offer advice.

Changes have already been made to the Case Create program which prompts the case create clerk to enter the date the employee stopped work (if applicable) and the date the employee returned to work, if available, for all lost time traumatic injury cases. This data will be used to identify cases appropriate for COP telephonic nurse intervention.

Triage codes will be used by the COP telephonic nurses, or Telephonic Case Managers (TCM) in cases with no full-time return to work. The codes, which will be checked off on the COP/RTW

Case Worksheet, allow the TCMs to alert the district office regarding cases in need of follow-up action. The triage codes are: "1" - no return to work due to surgery, invasive diagnostic testing, hospitalization or catastrophic injury; "2" - no return to work due to other reasons; "3" - part-time return to work; "4" - claimant not cooperating with nurse.

System enhancements are planned to include new QCM status codes for COP-QCM cases and to automatically create QCM records on accepted cases with triage codes.

Purpose: To provide COP telephonic nurse guidelines for Staff Nurses, TCMs, and claims staff.

Applicability: Regional Directors, FEC District Directors, Claims Examiners, Supervisors, Technical Assistants, Staff Nurses and Vocational Rehabilitation Specialists

Action:

Staff Nurse Responsibilities

1. Each District Office should recruit COP/TCMs from the existing TCM nurses or existing field nurse pool. Cases assigned to the COP/TCM can be in addition to cases assigned in the normal rotation. If a selection is made from the existing TCM nurses, the fees paid for cases assigned under the COP nurse intervention program will not be counted toward their income cap. The Staff Nurse (SN) should recruit at least two COP/TCM per state/territory serviced by the district office and must ensure that each COP/TCM possesses all RN licenses needed to cover their assigned area.

2. COP/TCM intervention will be telephonic only and is limited to a maximum intervention period of thirty days. No extensions of this thirty-day period will be permitted.

3. In those cases where there is no "RETURN TO WORK DATE" and fifteen days have elapsed since the date the claimant stopped work, a daily report will be produced listing those injury claims with no return to work. (See Attachment 1 - Sample COP/RTW Tracking Nurse Referrals.) All traumatic injury cases with lost time will be reported, including unadjudicated cases. This report will be e-mailed to the SN for assignment to the COP/TCM. She or he will then e-mail this list to the COP/TCM for action. This listing will show claim number, date referred, and employing agency (EA) contact name and telephone number for each selected case. The claim number will remain on the list until the COP/TCM enters a date of first telephone call or the case is closed. The daily e-mail listing received by the SN will be sorted first by state and then by date referred with the most recent referrals appearing at the top of the list.

4. The COP/TCM will be reimbursed at a "global fixed fee" rate of $100.00 per case. This amount represents reimbursement for both the professional and administrative services on the case and will be paid only at case closure using the unique code: COPTN (COP telephonic nurse). Reimbursement must be claimed on an HCFA-1500 and submitted with the completed

COP/RTW Case Worksheet.

5. Once the COP/TCM has closed a case, the SN will forward the COP/RTW Case Worksheet with any recommendations to the CE.

COP/TCM Nurse Responsibilities

1. Upon receipt of the e-mail list from the SN, the COP/TCM will access a web-based "home page," which will provide relevant claimant information for all cases referred. (See Attachment 2 - Sample COP/RTW Case Update screen.) Claimant information available to the COP/TCM will include: the claimant's name and telephone number, date of birth, date of injury, a narrative diagnosis, the employer's name and telephone number, and case status. The COP/TCM will also be able to ascertain whether the claim has been reviewed by the CE or is a short-form closure case. This information will appear as Initial Claim Adjudication, and will be Short Form Closure; Pending; Accepted, Denied. If the case is in a denied status, no further input will be permitted. A prompt at the bottom of the screen will state RECORD COMPLETE/CLOSED; NO FURTHER UPDATE ALLOWED.

2. After accessing the "home page," if the record is not complete or closed, the COP/TCM will initiate a telephone call to the EA to ascertain the claimant's return to work status. If contact with the EA is unproductive, the COP/TCM should initiate contact with the claimant to discuss return to work capabilities/status.

3. The "home page" will also permit access to the new COP/RTW Case Update screen for data entry by the COP/TCM. If the claimant has returned to work, the COP/TCM will input into this screen the date of the telephone call, to whom the call was made, the date of the claimant's return, whether the return was part-time or full-time, and whether the return was to regular duty or light duty. In cases where the claimant is losing intermittent time from work, the "DATE RETURNED TO WORK" will be the claimant's most recent return to work. The COP/TCM should also respond to "DID THE CLAIMANT USE 45 DAYS OF COP?" prompt, with "Y" for yes or "N" for no. The COP/TCM should ask this question of the claimant or the EA and enter the answer provided. If no answer is yet available, an entry in this field is not required. The COP/TCM will then close the file, input the date of closure in the COP/RTW Case Update screen and forward a completed worksheet to the SN. (See Attachment 3 - Sample COP/RTW Case Worksheet.)

4. A total of three calls should be attempted by the COP/TCM to reach either the claimant or the EA. If the claimant has not returned to work and there is some indication either from the claimant or the E/A that a return to work is planned within one week, the COP/TCM will note the projected return to work date on the COP/RTW Case Worksheet. The COP/TCM should then contact the claimant as soon as possible following the return to work date to verify that the return to work did occur. Once confirmed, the return to work date, type (i.e., full-time, part-time, regular or light duty) is entered into the COP/RTW Case Update screen. The date of

the follow-up telephone call should be entered as well. The COP/TCM will then close the file, input the date of closure in the COP/RTW Case Update screen and forward a completed COP/RTW Case Worksheet to the SN.

5. If the claimant does not have a plan to return to work and/or has not returned to work by the second contact, the COP/TCM will initiate a call to the attending physician (AP) to request updated medical reports and physical limitations for a return to work. The AP should be requested to provide this information directly to the district office. The COP/TCM should then document this as the final call in the COP/RTW Case Update screen.

6. For those cases where the claimant does not return to work within the thirty-day intervention period, the COP/TCM will terminate the intervention and complete the COP/RTW Case Worksheet, including the appropriate triage code and recommending future actions to be taken by the CE. The COP/RTW Case Worksheet will be forwarded to the SN. Once the thirty-day intervention period has ended, the COP/TCM will not be permitted to input any further data into the COP/RTW Case Update screen. Under no circumstances will this period be extended.

7. At specific points in the case intervention, it will be appropriate for the COP/TCM to cease intervention, enter the data into the COP/RTW Case Update screen, document the details (return to work, no return to work, medical information obtained, etc.) and return all claimant related information to the SN who will distribute it to the appropriate CE. If, in the course of intervention activities, the COP/TCM discovers: A) the AP is planning imminent surgery prior to release for return to work; B) the AP is planning any invasive diagnostic examination; C) the claimant's injuries are catastrophic; or D) the claimant refuses to discuss his/her case with the COP/TCM, intervention ceases immediately. The COP/TCM will inform the claimant that the CE will be handling the case. The COP/TCM will record the appropriate triage code on the COP/RTW Case Worksheet, input the appropriate data into the COP/RTW Case Update screen and forward all documentation to the SN.

8. The COP/TCM should claim reimbursement at a "global fixed fee" rate of $100.00 per case. This amount represents reimbursement for both the professional and administrative services on the case and will be paid only at case closure using the unique code: COPTN (COP telephonic nurse). Reimbursement must be claimed on an HCFA-1500 and submitted with the completed COP/RTW Case Worksheet.

Claims Examiner Responsibilities

1. The CE should promptly input a return to work date, if he or she becomes aware of that information prior to the COP/TCM, by accessing Case Management Screen 41 (also listed as COP/RTW Case Update). The CE should include whether the return was full-time, part-time, regular, or light duty by completing the field marked "RTW TYPE." After a return to work date has been entered, the record will be locked and no further data input will be permitted.

2. In cases where the claimant is losing intermittent time from work, the "DATE STOPPED WORK" will be the first date the claimant stopped work and the "DATE RETURNED TO WORK" will be the claimant's most recent return to work. The CE should also respond to "DID THE CLAIMANT USE 45 DAYS OF COP?" prompt. Valid entries are "Y" and "N." An entry in this field is not required if the answer is not known.

3. The CE may view information recorded by the COP/TCM in Query screen 12, COP/RTW Case Update.

4. All short-form closure cases with a part-time return to work and 45 days or less of COP used will "flip" to UD status with an expired call-up note. The CE must then expedite adjudication and immediately initiate QCM, including referral to a field nurse. A QCM record should be created using the part-time return to work date as the track date.

5. Receipt of a completed COP/TCM Case Worksheet indicating a part-time return to work on an accepted case should also prompt immediate QCM action.

6. Once thirty-five days have elapsed since the claimant stopped work and no "RETURN TO WORK DATE" has been input, all short-form closure cases which meet the criteria for COP nurse intervention will "flip" to UD status with an expired call-up note. The CE must then expedite adjudication, and initiate QCM action, including referral to a field nurse. A QCM record should be created using the date of injury as the track date.

7. Receipt of a COP/TCM Case Worksheet which shows that there has been no return to work due to surgery, invasive diagnostic testing, hospitalization or catastrophic injury (triage code 1), or that the claimant is not cooperating with the nurse (triage code 4) on an accepted case should also prompt immediate QCM action.

8. Upon initial acceptance of a traumatic injury claim, the CE will be prompted to enter a COP/RTW date if the COP/RTW record is not complete. A response will be required. For cases not meeting the criteria for referral to the COP/TCM the prompt will read "DID THE CLAIMANT STOP WORK FOLLOWING THE INJURY? (Y/N)". Valid entries are "Y" or "N". A "Y" response will open the COP/RTW Case Update window. For cases that have been referred to the COP/TCM the prompt will read "HAS THE CLAIMANT RETURNED TO WORK? (Y/N/U)". Valid entries are "Y", "N" or "U" (unknown). A "Y" response will also open the COP/RTW Case Update window. If the response is "N" and forty-five to sixty days have elapsed since the "DATE STOPPED WORK", the CE will be prompted with the question "DID THE CLAIMANT USE THE FULL 45 DAYS OF COP?". The CE may answer "Y" or "N" or may skip this field by using the Tab, Space or Enter keys. If it has been over sixty days since the "DATE STOPPED WORK" the system will automatically set the "DID THE CLAIMANT USE THE FULL 45 DAYS OF COP?" to yes. If the response is "U," neither the "RETURN TO WORK DATE" nor the "DID THE CLAIMANT USE THE FULL 45 DAYS OF COP?" fields will be updated.

9. Once a claim has been denied, no entry will be permitted in the COP/RTW Case Update screen.

10. If a Timely Payment of Compensation claim (TPCUP)is later paid for wage loss on a COP-QCM case with no return to work, the QCM track date should be changed to reflect the first date claimed on the paid Form CA-7. If a TPCUP record is later paid for wage loss on a COP-QCM case with part-time return to work, the track date should be changed to reflect the decision date on the approved CA-7 record. A weekly COP-QCM Cases Report will identify any cases with accepted wage loss claims whose track dates have not been changed.

11. QCM cases closed during the COP period for return to work full-time in regular or light duty should have their records "zeroed out". System enhancements are planned that will utilize the new COP-QCM status codes to automatically perform this function.

District Office Systems Manager Responsibilities

1. On a weekly basis, the Systems Manager in each district office will run two reports that identify cases for expedited adjudication and QCM action. Both reports will be sorted by responsible CE and triple-terminal digit.

> a) The Adjudication Triage Report will identify UN/UD cases with either no return to work (when > 35 days since date stopped work) or part-time return to work (when ≤ 45 days since date stopped work). The report will provide the claim number, claimant name, number of days elapsed since date stopped work, return to work date and type (if applicable), and the date of COP/TCM closure (if applicable).
>
> b) The QCM Referral Triage Report will identify accepted cases with either no return to work or part-time return to work, COP/TCM closure and no QCM activity. The report will provide the claim number, claimant name, number of days elapsed since date stopped work, return to work date and type (if applicable), number of days elapsed since COP/TCM closure, and accepted ICD-9 codes.

2. On a weekly basis, the Systems Manager in each district office will run a report that identifies COP-QCM cases with wage loss and no adjustment to the QCM record. The COP-QCM Cases report will identify QCM cases in categories A, B or C with a track date equal to the date of injury, or a track date equal to the return to work date and part-time return to work, and a CA-7 with decision codes of A1/2 or I1/2. The report will provide the claim number, claimant name, decision date on approved CA-7 record, and beginning date claimed on the paid Form CA-7.

Disposition: Retain until the expiration date or until superseded.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

ATTACHMENT 1 - 03/15/2000 COP/RTW TRACKING NURSE REFERRALS

CASE NO	CITY	STATE	CLAIMANT PHONE	REFER DATE	AGENCY
502222293	BALTIMORE	MD	(999) 999-9999	03/15/2000	1100FF
Agency Contact			( ) -		
505055569	GAITHERSBURG	MD	(202) 693-1029	03/15/2000	560000
Agency Contact: INJURY COMPENSATION SUPERVISOR (617) 654-5525					
505555595	BATTLE CREEK	MD	(616) 962-6646	03/15/2000	2150BB
Agency Contact: CASE MANAGER			(804) 771-2900		
505555596	WASHINGTON	DC	(616) 968-0191	03/09/2000	2150EE
Agency Contact: CASE MANAGER			(804) 771-2900		
156666666	WASHINGTON	DC	(203) 637-4146	03/01/2000	2520BU
Agency Contact: INJURY COMPENSATION OFFICER (617) 273-7332					
505555569	BOSTON	MD	(301) 555-1212	03/01/2000	2520BU
Agency Contact: INJURY COMPENSATION OFFICER (617) 273-7332					
015555666	BOSTON	DC	(301) 555-1212	02/14/2000	560000
Agency Contact: INJURY COMPENSATION SUPERVISOR (617) 654-5525					
062000007	ALEXANDRIA	VA	(707) 555-1212	02/10/2000	99995J
Agency Contact: NOT FOUND IN DEPARTMENT AGENCY TABLE (V01).					

ATTACHMENT 2 - COP/RTW Case Update

ATTACHMENT - 3 COP/RTW CASE WORKSHEET

Worksheet - Page 1

Worksheet - Page 2

FECA BULLETIN NO. 00-16

Issue Date: September 5, 2000

Expiration Date: September 4, 2001

Subject: Bill Payment/BPS - Pharmacy Fee Schedule Change

Background: Effective January 4, 1999, a fee schedule for prescription drugs was implemented for charges processed on and after that date. The formula for computing the allowable fee was based upon the two-year high average wholesale price (AWP), plus a dispensing fee equal to 20% of the AWP. The dispensing fee could not be less than $2.50, nor greater than $15.00. The calculated amount was then rounded up to the nearest whole dollar.

Effective September 5, 2000, the formula for computing the allowable fee for prescription drugs will be changed, and will be applicable to prescriptions filled on and after September 5, 2000. The new formula will be based upon 95% of the two-year high AWP, plus a set dispensing fee of $4.00. The calculated amount will no longer be rounded up to the nearest whole dollar.

A private vendor is still the source of the AWP information. The data is updated weekly. The web page for performing pharmacy fee calculations has been revised to apply the new calculation formula. For dates of service prior to September 5, 2000, the allowable fee should be calculated manually using the AWP available on the web page.

Reference: FECA Bulletin No. 99-07, issued January 4, 1999.

Purpose: To communicate new formula for calculation of the allowable fee for prescription drugs.

Applicability: Claims Examining, Bill Processing and Contact personnel, and Coding Specialists.

Actions:

1. Prescription drug calculations for allowable fees should be performed in accordance with the following formula for service dates on and after September 5, 2000:

(AWP X quantity X 95%) + $4.00

2. If the calculated amount is less than the billed amount, the calculated amount is the payable amount. If the billed amount is less than the calculated amount, the billed amount is the payable amount.

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

DEBORAH B. SANFORD
Acting Director for
Federal Employees= Compensation

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

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FC 00-04 Selected ECAB Decisions for April - June, 1999 (11/99B)

FC 00-06 Current Interest Rates for Prompt Payment Bills and Debt Collection (02/00A)
Attachment 1 Prompt Payment Interest Rates
Attachment 2 DMS Interest Rates

FC 00-07 Code changes for the Departments of the Army, Defense, Labor, State, Transportation, and Veterans Affairs, and the U.S. Postal Service and Other Establishments, Case Management Users' Manual, Appendix 4-7 (03/00A)

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FC 00-13 Dual Benefits – Authorization and Earnings Information from Social Security Administration (09/00A)
Attachment Form SSA-581

FECA CIRCULARS (FC)--TEXT

FECA CIRCULAR NO. 00-01 **October 5, 1999**

SUBJECT: FolioVIEWS Job Aid

Recently we have received several questions about the use of FolioVIEWS. Since the Job Aid currently in use has not been updated in some time, we have decided to revise and reissue it.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

Folio VIEWS 3.11 Quick Start Job Aid

Folio VIEWS 3.11 operates under Windows 95 and uses many Windows conventions for file access, editing, viewing, formatting, etc. And, like other Windows applications, Folio VIEWS gives you multiple ways of doing the same thing. For example, to display the Query window, you may 1) Click on the Query button on the Toolbelt, or 2) Press the F2 key, or 3) you may press Alt+S, followed by Q, or 4) use the Menu Bar by clicking on Search, then on Query. It is advisable, when first using Folio VIEWS, to walk through each of the functions below.

To **OPEN** an infobase ~ Double-click on the desired infobase name in the Infobase Directory listing. You may open more than one infobase, and search on one or all open infobases. (See To SEARCH, below.) You may also click on the Open button on the Toolbelt, scroll through the filenames, and double-click on the infobase you want to open.

To **CLOSE** an infobase ~ Click on the Close button on the Toolbelt.

To **EXIT** Folio VIEWS ~ Click on the **x** in the upper right corner of the application window, or press Alt+F4.

To use **HELP** ~ Position the cursor on Help option on the Menu Bar at the top of the screen and click once. Click on Contents to get fast access to Tutorials, the Menu Bar, Quick Keys, Using the Help system, and a Glossary.

To **SEARCH** ~ Click on the Query button on the Toolbelt (or you may press F2; or press Alt+S followed by Q; or use the Search menu on the Menu Bar). When the Query window is displayed, enter the query text and click on OK to search the infobase. If you have more than one infobase open and wish to search against all of them, click on Apply to All.

LINK TO IMAGE ~ to see the image, double-click on the link. This will display the image in a viewer window. To return to the infobase text, click once on the **x** in the upper right corner of the **viewer window** (the lower set of window-sizing boxes).

To **BLOCK & COPY TEXT** to a Word document ~

Open a Word document and toggle back to Folio VIEWS.
Position the cursor at the beginning of the infobase text you wish to copy.
Hold down the left mouse button and move the mouse (or use Shift +arrow keys) to highlight all text to be copied.
Click on the Copy button on the Folio VIEWS Toolbelt.
Toggle back to the Word document. Place the cursor where you want to paste the text.
Click on Edit on the Menu Bar at the top of the Word document window.
Click on Paste.

To **BLOCK & PRINT** text ~

Position the cursor at the beginning of the text you wish to print.
Hold down the left mouse button and move the mouse (or use Shift +arrow keys) to highlight all text to be printed.
Click on File on the Menu Bar at the top of the window.
Click on Print.
Click on OK.

To **PRINT image objects (Link to Image)** ~
Double-click on an object labeled **Link to Image** to display it.
Click on File on the Menu Bar.
Click on Print. The Print Object window will appear.
In the Options box you may adjust the number of copies.
Click on OK.
If you get a message that says the object is too large to fit, click on Yes, and the size of the image will be decreased so that it will fit on a page. You may need to go to Print Setup to select legal sized paper in order to get a legible printout.

Standard Toolbelt Buttons

OPEN ~ Displays an Open dialog box. Double-click on an infobase name to open it. You may also double-click on an infobase name in the Infobase Directory to open an infobase.

CLOSE ~ Closes the infobase.

COPY ~ Copies highlighted text or selected in-line images to the clipboard, ready to be pasted into MS Word or another Windows application.

QUERY ~ Opens the Query dialog to search the infobase. Click on the Query button on the Toolbelt. Enter your query in the Query window and click on OK. (See To SEARCH, on p. 1.)

CLEAR QUERY ~ Clears the current query (highlighted words).

NEXT ~ While viewing results of a query, click on Next to advance the cursor to the next occurrence of the query text.

PREVIOUS ~ While viewing results of a query, click on Previous to return the cursor to the last prior occurrence of the query text.

BACKTRACK ~ Takes you back, in reverse order, through the links you have followed and the searches you have performed.

TRAIL ~ Click once on the Trail button to get a map of those links you have followed within

the infobase. Double-click on any line in the trail to return to that location.
CONTENTS ~ Displays the infobase internal Table of Contents from the current position in the text. The TOC is a navigational tool designed to help you easily browse through the infobase.

GO TO ~ Permits you to jump from the current record (paragraph) in an infobase to another record in the file (by record number).

INFO ~ Shows you the last time the infobase was modified and a history of modifications.

Selected Quick Key Keystrokes

File Options

Ctrl+O	Open
Alt+F4	Exit Folio VIEWS
Ctrl+F4	Close current infobase

Navigating

Ctrl+Home	Top of Infobase
Ctrl+End	End of Infobase
Ctrl+Enter	Activate Link
Ctrl+Tab	Next Window (i.e., move between open infobases)
Ctrl+Shift+Tab	Previous Window
Ctrl+G	Go To
F1	Help
F2	Search
F3	Find Next
F4	Find Previous
F5	Backtrack
Alt+S+Q	Search
Ctrl+F6	Next Window (i.e., move between open infobases)
Ctrl+Shift+F6	Previous Window
Ctrl+T	Table of Contents Window/Document Window toggle

Table of Contents Window

+	Expand Branch One Level
-	Contract Branch One Level
*	Expand Entire Branch
1-9	Expand All Branches to a specific level
Alt+S+C	Contract Branch One Level
Alt+S+R	Clear Query
Ctrl+T	Return to the Document Window

Other

Alt+S+Q	Search
Alt+S+R	Clear Query
Ctrl+C	Copy
Ctrl+Insert	Copy
F1	Help
F6	Tag Record/Clear Tag

FECA CIRCULAR NO. 00-02 **December 20, 1999**

SUBJECT: Representative Fee Petitions

The FECA Regulations at 20 CFR 10.703(a)(1) discuss the requirement that representatives submit their fee applications "to the district office and/or the Branch of Hearings and Review, according to where the work for which the fee is charged was performed." This provision has caused some confusion, as it is sometimes the case that services have been provided both before the custodial district office and the Branch of Hearings and Review during the life of the claim. Often representatives will 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 file at the time the fee petition 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.

Therefore, it is necessary that any fee petition presented to an office for a case over which that office does not have jurisdiction be routed promptly to the custodial office so that it may be considered.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 00-03 **November 5, 1999**

SUBJECT: DUAL BENEFITS – FERS COLA

Effective December 1, 1999, Social Security Benefits will increase by 2.4%. That requires the amount of the FERS Dual Benefits Deduction to be increased by the same amount.

This adjustment will be made from the National Office and will affect all cases that are correctly entered into the ACPS Program. The adjustment will be made effective with the periodic roll cycle beginning December 5, 1999. No adjustment will be made for the period December 1, 1999 through December 4, 1999.

If there are any cases currently being adjusted for FERS Dual Benefits that have not been entered correctly, please ensure that the correction is made by December 1, 1999.

The National Office will provide a notice to each beneficiary affected. A copy will be provided for each case file.

SSA COLA's are as follows:

Effective December 1, 1999	2.4%
Effective December 1, 1998	1.3%
Effective December 1, 1997	2.1%
Effective December 1, 1996	2.9%
Effective December 1, 1995	2.6%

Effective December 1, 1994	2.8%

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 00-04 **November 23, 1999**

SUBJECT: SELECTED ECAB DECISIONS FOR APRIL - JUNE, 1999

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

Several decisions involving termination under 5 U.S.C. 8106(c) for failure to accept suitable employment are included. There have been a large number of reversals in this area for a variety of reasons. Other subjects include performance of duty, pay rate for a court reporter, grandchildren as dependents for purposes of augmented compensation, consequential injury, schedule awards, loss of wage-earning capacity, forfeiture for failure to report earnings, weight of an impartial examination when there is no conflict, and notification of impartial case reviews in death claims.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

CONSEQUENTIAL INJURY

Billy T. McNatt, Docket No. 97-804, Issued April 14, 1999

This decision provides an interesting discussion of the basis for determining when an injury can be considered consequential.

In this case, the claimant sustained a traumatic injury on November 6, 1990 that was accepted as resulting in an acute back strain. The Office subsequently accepted a herniated nucleus pulposus (HNP) at C5-6, with a C5-6 and C6-7 diskectomy/fusion, and pain in the right shoulder.

The Office additionally authorized a June 8, 1994 surgery to repair a torn rotator cuff of the right shoulder.

A subsequent recurrence was claimed commencing July 3, 1995. This period of disability occurred when the claimant was attempting to lift an empty propane tank out of the back seat of his truck while away from work. The Office denied this recurrence claim noting that this constituted a new, non-work-related injury.

The Board stated, "It is an accepted principle of workers' compensation law, and the Board has so recognized, that when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct."

The Board then cites Larson:

> When the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of 'direct and natural results' and of claimant's own conduct as an independent intervening cause.
>
> The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.

The Board goes on to opine, "Thus it is accepted that once the work-connected character of any condition is established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause. If a member weakened by an employment injury contributes to a later fall or other injury, the subsequent injury will be compensable as a consequential injury. If further complication

flows from the compensable injury, *i.e.* so long as it is clear that the real operative factor is the progression of the compensable injury, with an exertion that in itself would not be unreasonable under the circumstances, the condition is compensable."

The Board remanded the case, directing the Office to discuss whether the claimant's activity in reaching behind the seat of his car to lift a propane can was reasonable in light of his preexisting condition. The Office was further directed to provide reasons for the finding of an independent intervening cause for the July 3, 1995 disability.

DEPENDENT GRANDCHILDREN - AUGMENTED COMPENSATION

Barbara J. Hill, Docket No. 97-871, Issued April 20, 1999
Lill Rollins, Docket No. 97-2780, Issued June 16, 1999

The decisions in these cases contrast with the decision in Clyde Stevenson (Docket No. 95-3016, issued February 4, 1998), which was summarized in FECA Circular 99-9. The Stevenson decision dealt with dependent grandchildren in a death claim. In the Hill and Rollins decisions, the appellants claimed augmented compensation on the basis that they had legal custody of their minor grandchildren.

Section 8110 of the FECA provides that a "dependent" for purposes of augmented compensation includes an unmarried child "while living with the employee or receiving regular contributions from the employee towards his support." In section 8101(9), a "child" is defined as one "who is under 18 years of age or over that age and incapable of self-support, and includes stepchildren, adopted children, and posthumous children, but does not include married children."

The Board found that a "grandchild" was not a "child" as defined in the Act, and therefore did not qualify a claimant for augmented compensation. These decisions serve to illustrate the differences in dependent status between disability and death cases.

FORFEITURE FOR FAILURE TO REPORT EARNINGS

Daniel A. Mashe, Docket No. 97-2115, Issued June 11, 1999

A forfeiture of compensation was declared for the period September 10, 1990 through June 27, 1992 on the grounds that the claimant concealed his employment at a liquor store during that time and did not report the employment as required under 5 U.S.C. 8106(b). The Office found that the claimant had failed to report his employment on Form CA-1032.

The claimant contended that he had performed no work, had no duties, and was not employed. A postal inspection report for the period in question reported that the claimant was observed many times working behind the counter, waiting on customers, working the register, and at times, minding the store by himself. The store had no records for the claimant, and the owner stated that he was not an employee, but that he did serve a security function, and would sometimes be in the store alone, waiting on customers. The claimant himself stated that he was at the store to pass time, and that he had known the owner for many years. He stated that he was at the store six days per week, four hours per day. He admitted that he did help out when needed. However, he also stated that he was not employed in the store, and received no remuneration, and that if he stopped going to the store, the owner would not hire anyone to replace him.

The Board found that the Office improperly declared a forfeiture for failure to report employment. They found that the claimant received no wages, tips, or other advantage in exchange for his activities at the store. They found that the evidence clearly established that the claimant was engaged in work activities for which he was not paid, and that his failure to report what it would have cost the store owner to hire someone to perform the work he performed might make him liable for criminal prosecution, and his compensation could be reduced to reflect his wage-earning capacity. However, without evidence of earnings or other remuneration, invoking the penalty provisions of section 8106(b)(2) was improper. The Board also noted that this situation was different from invoking the forfeiture penalty in cases where the claimant has been self-employed in a family-owned business. In this claim, the employee had no financial interest in the store.

IMPARTIAL EXAMINATION - NOTIFICATION REQUIRED IN DEATH CLAIMS

Rosita Mahana, claiming as widow of Wayne Mahana, Docket No. 97-92, Issued April 13, 1999

A claim for death benefits was filed, contending that the death of the employee by suicide was related to employment factors. The widow submitted medical evidence that supported the claim. The Office referred to case record to a specialist for a second opinion review. The second opinion reviewer did not support a causal relationship between the employee's work and his death, and the Office determined that there was a conflict of medical opinion, necessitating review by an impartial specialist. The case record was referred to an impartial psychiatrist, but a copy of the referral letter was not sent to the widow or to her representative. Following the review, the Office advised the widow that the claim had been reviewed by an impartial specialist, who stated that the employee's death was not due to his employment.

The widow's attorney objected to the referral of the case record for impartial review without notification to either the widow or himself. The Office responded that since only a review of the record was required, they did not notify the widow or her representative. The claim for survivor's benefits was rejected on the basis that the employee's death was not related to employment factors.

The Board found that the case was not in posture for a decision. They noted that the Office properly determined that there was a conflict of medical opinion. They cited the Federal (FECA) Procedure Manual, Chapter 3.500.4d, which states, "Notification that the examination is being arranged under the provisions of 5 U.S.C. 8123 will give the claimant an opportunity to raise any objections to the selected physician prior to the examination." The Board found that this provision applies equally to death and disability claims, and that by failing to notify the widow in the instant claim, she was deprived of the opportunity to present reasons for participating in the selection of the impartial examiner. The Board remanded the claim for a new impartial review, with proper notification to the interested parties.

IMPARTIAL OPINIONS - NO SPECIAL WEIGHT IF NO CONFLICT OF MEDICAL OPINION

Rochelle Wenkowsky, Docket No. 97-2253, Issued May 19, 1999

In this case, the claimant returned to work in a light-duty capacity for four hours per day. By decision dated May 18, 1995, the Office determined that the claimant's earnings in this light-duty position fairly and reasonably represented her wage earning capacity.

The Office subsequently terminated all compensation on the grounds that the weight of the evidence established that the claimant did not have a continuing employment-related disability.

The Board noted that, although the Office based their decision to terminate compensation on the medical opinion of an impartial medical specialist, Dr. Mulle, no unresolved conflict existed on the issue of whether the claimant's employment-related condition had resolved.

A second opinion referral physician, Dr. Infranca, had stated that the claimant was capable of initially returning to work for four hours per day with restrictions. The claimant's treating physician, Dr. Goldberg, also released the claimant to return to work initially four hours per day with restrictions.

The Board further noted "While there may have been minor differences between Drs. Goldberg and Infranca as to the specific restrictions in a light-duty job, both of the physicians appear to agree that appellant continued to have an employment-related disability. Dr. Infranca's suggestion that appellant could return to full-time light duty after one week does not provide a reasoned opinion that appellant's employment-related disability or condition had ceased, and therefore his report cannot create a conflict on these issues under section 8123(a). Dr. Mulle is therefore not considered an impartial medical specialist whose opinion may be entitled to special weight, but rather a second opinion physician."

The Office's decision, with respect to the issue of continuing employment-related disability, was reversed.

LOSS OF WAGE-EARNING CAPACITY BASED UPON CONCURRENT EMPLOYMENT

Dim Njaka, Docket No. 96-1950, Issued June 18, 1999

The claimant, a mailhandler for the Postal Service, injured his upper back in September 1988, in the performance of duty. His claim was accepted for left shoulder and neck strain, and several herniated discs. He worked light duty until stopping work on December 19, 1988, and returned to work on January 21, 1989. Prior to the date of his injury, and until September 5, 1990, the claimant was also employed as a programmer analyst in a bank, with earnings of $20,000 per year. Beginning in January 1989, he was also self-employed as a computer consultant, with no reported earnings. Between an unknown date in 1990 and November of 1992, he worked for General Mills, with an annual salary of $37,000. He apparently continued his concurrent employment after November 1992, but the nature of that employment is not detailed in the decision.

The claimant stopped working for the Postal Service altogether on February 2, 1990, due to partial disability. A temporary job offer was made, and the Office terminated wage loss benefits after February 16, 1990, based on failure to demonstrate total disability. A hearings representative found that the job offered was only available for a short time, the claimant was still partially disabled, and he was entitled to compensation for a loss of wage-earning capacity based on actual earnings as of February 5, 1990, pending a formal LWEC decision. After confirming partial disability through a second opinion evaluation, the National Office modified the hearing representative's decision, and directed the District Office to pay compensation beginning February 5, 1990, using a constructed LWEC, considering the earnings in private industry.

After referral to the rehabilitation specialist, the District Office issued a decision finding no loss of wage-earning capacity as of February 5, 1990, based upon potential earnings for the selected position of programmer/analyst being higher than the contemporaneous salary for the Postal job held on date of injury. The claimant requested a hearing, and cited the Board's decision in *Irwin E. Goldman* (23 ECAB 6[1971]) as support for his argument that his concurrent employment could not be used as the basis for an LWEC. The hearing representative affirmed the Office's determination that the claimant had no loss of wage-earning capacity based on the constructed position of programmer/analyst, but that the Office should have reinstated compensation for total disability pending its determination, and provided due process through a prereduction notice. The hearing representative stated that the hearing decision would represent the prereduction notice. The District Office subsequently issued the final decision to reduce compensation to zero as of March 14, 1995. The claimant again requested a hearing, and the hearing representative affirmed the decision.

The claimant then requested an appeal, and the Board also affirmed the decision. They noted that the *Goldman* decision established the principle that earnings from dissimilar concurrent employment could not be included in the pay rate for compensation purposes, and consequently for establishing a wage-earning capacity. In this instance, the Office did not rely upon the actual earnings, but pursuant to section 8115 of the Act, chose a general position that represented his wage-earning capacity. Although the selected position was basically similar to the work he performed in private industry, it was selected in accordance with the factors outlined in section 8115, namely, the degree of impairment, usual employment, age, qualifications, and availability.

LOSS OF WAGE-EARNING CAPACITY BASED ON POTENTIAL COMMISSIONS

Barbara Pargament, Docket No. 97-1144, Issued June 7, 1999

The Office accepted the claimant's case, and she was placed in a six-month on-the-job training program for work as a real estate agent, property manager, and leasing agent. At the end of the training program, she started working full-time on a commissions-only basis. The rehabilitation counselor stated that expected earnings from commission for a real estate agent were $25,000 to $32,000 per year.

Using the $25,000 per year figure, the Office determined that the position of real estate salesperson fairly and reasonably represented her wage-earning capacity, and reduced compensation accordingly. In addition, they computed an overpayment based on that same amount for the period between when she started working and when the reduction in benefits was made. The claimant did not respond to the initial overpayment notification, and so the finding that claimant was with fault was made final, and the overpayment was withheld from continuing compensation at the rate of $300 each 28 days.

The Board found that basing the claimant's wage-earning capacity on the $25,000 figure was improper, as was the overpayment. They found that the Office did not follow the procedures outlined in *FECA Program Memorandum No. 128* and the case of *Donald R. Shively (22 ECAB 34 [1970])* for determining wage-earning capacity based solely on commission. In *Shively*, the Board stated:

> Where a wage-earning capacity rating is to be made on the basis of commissions only, the claims examiner should obtain information as to the average number of weeks, or months it takes for a starting person to reach the level of commissions used as the basis of wage-earning capacity rating. Compensation should then be paid on the basis of the claimant's actual wage loss for that period of time. Thereafter, compensation should be paid on the wage-earning capacity rating which is predicated on the commission.

LOSS OF WAGE-EARNING CAPACITY - RETROACTIVE

Bridgett T. Davis, Docket No. 96-1951, Issued June 23, 1999

The claimant's injury occurred in 1983, and a recurrence beginning in May 1985 was accepted as related to the original injury. Although medical expenses were paid, no claim for compensation due to the recurrence was made until 1990. The claimant had several jobs as teacher and instructor on an intermittent basis beginning in August 1985. Her yearly earnings ranged from a low of $598.66 in 1989 to a high of $11,212.20 in 1991.

The Office issued a decision finding no loss of wages based on the selected position of secondary school teacher, for which the claimant was certified in the state of Florida. The salary for a secondary school teacher in the claimant's area of residence exceeded the concurrent wages for the job she held on date of injury.

The Board found that the case was not in posture for a decision, and remanded the case for further development and a *de novo* decision. When making a retroactive loss of wage-earning capacity determination, the Office must first determine whether there are actual earnings, and if so, must follow the procedures for determining loss of wage-earning capacity based on actual earnings, found in the *Federal (FECA) Procedure Manual, Chapter 2-0814*. In this case, the claimant had actual earnings, but these earnings were not discussed, nor was there a finding made that the earnings did not represent the claimant's wage-earning capacity, prior to proceeding with a rating based on a selected position.

MERIT REVIEW - ABUSE OF DISCRETION

Ronald H. Lunsford, Docket No. 97-1178, Issued April 26, 1999

In this case, a claim was filed for work-related aggravation of a preexisting emotional condition. After development, the office denied the claim on the basis that causal relationship was not established. Reconsideration was requested on the basis that the Office failed to clearly delineate whether fact of injury was accepted, and which elements of the employment were accepted as compensable. The request for modification was denied on the basis that the arguments submitted were not sufficient to warrant modification of the prior decision. The Office did state that it was accepted that the claimant experienced stress due to the volume of work.

The claimant again requested reconsideration, and described his fear and anxiety regarding his ability to carry out his duties, overwork, understaffing, overtime, and deadlines. The reconsideration was denied on the basis that the submitted evidence was cumulative in nature and insufficient to warrant a merit review. The claimant appealed the decision.

The Director filed a motion recommending that the case be remanded to the District Office for further development, because the claimant had established fact of injury and submitted medical evidence in support of causal relationship sufficient to require the Office to undertake further development. The Board remanded the case for further development, to be followed by a de novo decision.

The Office referred the case out for a second opinion evaluation. The statement of accepted facts listed understaffing (with no staff counselor) and a heavy caseload as compensable work factors. The second opinion physician examined the claimant and the records, and submitted a report to the Office in which he stated that the claimant's underlying condition had been aggravated "a little bit by his work-related condition," and that the aggravation had ceased.

The Office wrote to the second opinion physician regarding the duration of the temporary aggravation. They pointed out that there were a number of work-related incidents which were not considered to be compensable factors of employment, and asked the physician to clarify "whether the condition was aggravated **solely** by the two compensable factors of employment that were set forth in the statement of accepted facts." They also asked that if "the condition was aggravated solely by **the two compensable factors of employment**," he should state when the aggravation ceased.

The physician responded that the condition was not due to the two compensable employment factors, but that the death of a coworker seemed to be a much greater stress than overwork or understaffing. The Office affirmed their prior decision, denying the claim for lack of causal

relationship.

The claimant requested reconsideration, asserting that the statement of accepted facts was incomplete, misleading, and contained improper and irrelevant material, and that the Office used an incorrect legal standard when they asked whether the claimed condition was based solely on the two accepted work factors. The claimant also stated that there was an unresolved conflict of medical opinion, and submitted another medical report from his attending physician. The Office denied reconsideration on the basis that the evidence submitted was immaterial, and that the new medical evidence was "vague" and "speculative" and therefore insufficient to create a conflict of opinion.

An appeal was filed, and the case was remanded to the Office for reconstruction and issuance of an appropriate decision. The Office subsequently again denied the request for merit review on the basis that the evidence submitted was repetitious and insufficient to warrant a merit review.

The Board found that the Office abused its discretion in denying the request for a merit review, and remanded the case for merit review. The Board found that the claimant had submitted new legal arguments with respect to the second opinion physician's report, and had also submitted new, relevant medical evidence. The Board noted also that the Office used an incorrect legal standard when they requested the supplemental report from the second opinion physician, because a claimant is not required to prove that work factors are the sole cause of a claimed condition. The Office had incorrectly asked the second opinion physician to state whether the condition was aggravated **solely** by the two accepted work factors.

PAY RATE FOR COMPENSATION PURPOSES - INCLUSION OF TRANSCRIPTION FEES

Daniel Shaw, Docket No. 97-1680, Issued April 14, 1999

The claimant in this decision was a court reporter whose claim was accepted, and who was entitled to compensation for loss of wages. The reported annual salary was $46,518 per year, but as much as an additional $60,000 per year was paid to the claimant for court transcriptions. He was required to provide transcripts in certain categories of cases, for which he was paid at rates set by the administrative body for the employing agency. The employee claimed that these additional amounts for transcripts should be included in his rate of pay for compensation purposes. The Office rejected the claim for inclusion of the transcription fees in his pay rate for compensation purposes on the basis that Office procedures did not provide for inclusion of such services.

The Board reversed the Office's decision. The claimant received payment for transcripts from both the Federal government and private individuals, and was permitted to receive such payment as part of his duties, in addition to his salary. Payments for the transcripts were for the product of duties he performed while in his salaried position.

The Board pointed out that even if one tried to argue that the claimant received payment for the transcripts though self-employment, not his regular duties, the "concurrent" earnings should be included in the rate of pay for compensation purposes because producing transcripts for private parties was similar to his regular duties of producing transcripts for the court (see Irwin E. Goldman, 23 ECAB 6 [1971]). The earnings from producing transcripts during the year prior to when his disability began should be included in his pay for compensation purposes.

PERFORMANCE OF DUTY - DEVIATION FROM ANTICIPATED ROUTE

Samuel Clay, Docket No. 97-2181, Issued May 11, 1999

In this case, the claimant was employed in a limited-duty assignment delivering mail to certain outlying employing establishment branches. He was involved in a motor vehicle accident on January 16, 1997, as he was returning to the main post office after delivering mail to a branch office.

The claimant initially explained that, due to traffic, he was not able to move into the appropriate lane to take the closest exit to the employing establishment so he continued on to the next exit. The claimant later alleged that he was hungry and had intentionally taken the second exit. He was in the wrong lane after he exited due to traffic.

On appeal, the claimant's attorney argued that he was never given a specific route to travel and had the discretion to use whatever route was most familiar to him and the most economical. The claimant's representative argued that the route taken by the claimant was the most familiar to him and he was, consequently, in the performance of his duties at the time of the motor vehicle accident.

The Board affirmed the Office's decision, stating, "The record in this case is clear that appellant had deviated from his anticipated route between Montgomery and Alexandria as he did not take the most direct route and did not take the appropriate exit for the route he chose. His reasons for being where he was, were inconsistent and unsupported by the facts of record. Because appellant deviated from the course of his employment for personal reasons and failed to regain his anticipated work route before sustaining his injury on January 16, 1997, his injury did not arise in the course of employment."

PERFORMANCE OF DUTY - "SPECIAL ERRAND" EXCEPTION

Asia Lynn Doster, Docket No. 96-688, Issued April 20, 1999

In this case, the claimant was involved in an motor vehicle accident which occurred on June 7, 1995, while she was driving to another "government building" to investigate a personal threat made against her.

Prior to adjudicating the claim, the district office conducted conferences with both the claimant and an employing agency supervisor. The supervisor indicated the claimant had received an anonymous threatening letter that was considered sufficiently serious to have the FBI and the employing agency investigate. The claimant was in leave status at the time of the motor vehicle accident and, to the best of the supervisor's knowledge, was not conducting any official business. The claim was denied on the grounds that the evidence of record failed to establish that the claimant had sustained an injury while in the performance of duty.

On appeal, the claimant's attorney argued that the claimant did not go directly to work on the date of the motor vehicle accident. Instead, she had contacted a colleague who was working as a law enforcement employee in a government building a short distance from her home. She met the employee, drove around the parking lot, and discussed the letter. She did not exit the vehicle due to her fear. After this conversation, the claimant proceeded to drive toward her home. However, she was hit broadside by a driver prior to her reaching her home. She assumed this incident was related to the threat made against her. The colleague from whom she sought guidance was the husband of the person scheduled to assume the position of manager of the facility where the claimant worked. The attorney contended that the claimant's actions could reasonably be interpreted as in furtherance of her employer's business.

The Board affirmed the Office's decision, finding, "The evidence of record does not establish that appellant was engaged on any special errand when she left her home. There is no evidence which would establish that appellant's journey on the date of injury was an integral part of any errand or special task either expressly or impliedly agreed to by her employer."

PERFORMANCE OF DUTY - WILLFUL MISCONDUCT

MaryAnn Battista, Docket No. 96-2501, Issued April 16, 1999

In this case, the claimant alleged that she injured herself on January 30, 1996, when she fell down a step and landed on both knees in the secured area of the mini-commissary. The employing agency controverted the claim, stating the claimant departed from her designated duty site without supervisory approval, and had entered an unauthorized office while conducting personal business at the time of the injury.

The evidence of record indicated that the claimant had been verbally advised on January 18, 1996, that she was not authorized to go in the mini-commissary. The record further indicated that the claimant was dropping off her daughter for work and looking for cigarettes in the mini-commissary. The claim was denied for the reason that the evidence of record failed to establish that the injury was sustained in the performance of duty.

The claimant requested reconsideration and submitted statements from herself and three witnesses which supported that on the date of injury, when she mentioned that she was going to the mini-commissary for a few minutes, she was asked to deliver several work-related items. She also stated that she was going to check on the availability of an item in response to a customer's telephone inquiry. After additional inquiry into the facts, the Office denied modification of the prior decision.

The Board found that the claimant was injured while in the performance of duty. The Board noted that the claimant had presented credible evidence in the form of witness statements that showed, at the time of the injury, she was engaged in activities which could be characterized as reasonably incidental to the conditions of her employment.

In addition, the Board held that the fact that the claimant entered an area where she was not authorized to go does not remove her from the performance of duty. "The mere act of disobedience of a rule or order does not necessarily place an employee outside the sphere of his employment so that he loses the benefits of the Act…the defense of willful misconduct has been used successfully in a narrow field of intentional violation of safety regulations. There is no evidence of record that the appellant's entry into the 'secured area' of the mini-commissary violated a specific safety rule of the employing establishment."

SCHEDULE AWARD - INCLUDING PREEXISTING IMPAIRMENT

Phillip R. Brueck, Docket No. 97-2487, Issued June 14, 1999

This claimant has an accepted partial meniscus tear. A prior schedule award decision for nine percent impairment of the left leg was remanded by the Board for further development. As part of that prior decision, the Board stated that Office should take into account the preexisting impairment of the left ankle when redetermining the award, even though the claim was not accepted for an ankle injury.

Upon receipt of the case from the Board, the office obtained a report from a Board-certified orthopedic surgeon. The report was referred to the Office medical advisor for review. The medical advisor found that the claimant had nine percent impairment of the leg, and that the orthopedic surgeon's calculation of 34 percent impairment incorrectly included 21 impairment for the non-work-related ankle condition, and a collateral ligament injury, which did not exist. The office denied the claim for an award above the nine percent that had already been awarded.

The Board set aside the decision and remanded the case for further action. They noted that there was a discrepancy between the examining orthopedist and the Office medical advisor regarding whether the ligament laxity was mild or moderate, and what role, if any, the collateral ligament played in this determination. The Board also noted that the Office had failed to heed their previous instruction to include the preexisting impairment of the ankle in the rating. The FECA does not provide for a schedule award of the knee alone, but of the leg. All impairments of the leg must be considered in determining a schedule award.

SUITABLE EMPLOYMENT - TERMINATION OF BENEFITS

Robert J. Cook, Jr., Docket No. 97-2171, Issued May 13, 1999
Nathaniel Davis, Docket Nos. 97-1565 & 97-2368, Issued May 13, 1999
Alicia A. Diaz, Docket No. 96-2414, Issued May 17, 1999
Regina F. Holt-Anderson, Docket No. 97-2084, Issued May 25, 1999
Kewel S. Khalsa, Docket No. 97-2404, Issued June 15, 1999
Laura Penzo, Docket No. 97-1842, Issued May 11, 1999
Onnie Pickens, Docket No. 97-1637, Issued May 14, 1999
Deborah E. Scott, Docket No. 97-2236, Issued May 12, 1999

In all of these decisions, the Board reversed the Office's decisions to terminate benefits due to refusal of suitable employment, and in most instances, benefits for total disability were reinstated retroactively.

Section 8106(c) of the FECA provides:

> A partially disabled employee who-
> (1) refuses to seek suitable work; or
> (2) refuses or neglects to work after suitable work is offered to, procured by, or secured for him;
>
> is not entitled to compensation.

Section 8106(c) permits the Office to terminate compensation benefits when a suitable job offer is refused. The process of determining a job's suitability is complex, and involves coordination with the employing agency and the treating or examining physicians. Because termination of compensation is such a severe penalty, application of sanctions under section 8106(c) must be performed with utmost care and consideration for the employee's rights.

The Office's errors in the decisions noted above fall into two broad categories. In the first group, which includes the decisions in Cook, Holt-Anderson, Khalsa, and Pickens, the Office notified the claimant that the job was suitable, and allowed 30 days for acceptance of the job or explanation of reasons for refusing the job. When the claimants responded within 30 days of the initial notification, giving reasons for refusing the job, the Office proceeded to find the reasons unacceptable and erroneously terminated benefits without notifying the claimant that the reasons for refusal were not accepted, and giving them an additional period of time within which to accept the job without penalty. Once the Office has made a final decision on the suitability of the job (i.e. after the claimant's reasons for refusing the job have been received and considered), the claimant must be so notified, and afforded a final chance to accept the job.

The other grouping of errors involved deficiencies in the medical evidence. In both Davis and Penzo, there were conflicts in the medical evidence concerning the claimant's ability to perform the offered job. These conflicts should have been resolved prior to finding the job suitable and terminating benefits. Additionally in Davis, the description of the physical requirements of the offered job were not sufficiently detailed to make a suitability determination. In Scott, medical evidence from several physicians supported that the claimant was able to work, but not with her previous employer, the Postal Service, and yet the offered job was with the Postal Service. In Holt-Anderson, the medical evidence that was alleged to support the suitability of the job was either speculative, or recommended further evaluation prior to a return to work. In Diaz, the claim was accepted for both orthopedic and psychiatric conditions, but the job suitability determination was made based upon orthopedic limitations only. The medical evidence of record contained a second opinion psychiatric report outlining work-related job restrictions that were more severe than those contained in the offered job, and no psychiatric specialist had found the offered job suitable.

Please note that during the period in which the Board reversed so many section 8106(c) terminations, there were also many decisions that were affirmed on the same issue.

FECA CIRCULAR NO. 00-06 **January 14, 2000**

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

The interest rate to be assessed for the prompt payment bills is 6.75 percent for the period January 1, 2000 through June 30, 2000.

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

The rate for assessing interest charges on debts due the Government has not changed. The rate of 5 percent continues to be in effect through December 31, 2000.

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

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

Attachments

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

ATTACHMENT 1 - Prompt Payment Interest Rates

PROMPT PAYMENT INTEREST RATES

Period	Rate
1/1/00 - 6/30/00	6.75%
7/1/99 - 12/31/99	6.5%
1/1/99 - 6/30/99	5.0%
7/1/98 - 12/31/98	6.0%
1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

ATTACHMENT 2 - DMS Interest Rates

DMS INTEREST RATES

1/1/00 - 12/31/00	5%
1/1/99 - 12/31/99	5%
1/1/98 - 12/31/98	5%
1/1/97 - 12/31/97	5%
1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%
1/1/95 - 6/30/95	3%
1/1/94 - 12/31/94	3%
1/1/93 - 12/31/93	4%
1/1/92 - 12/31/92	6%
1/1/91 - 12/31/91	8%
1/1/90 - 12/31/90	9%
1/1/89 - 12/31/89	7%
1/1/88 - 12/31/88	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%
Prior to 1/1/84	not applicable

FECA CIRCULAR NO. 00-07 **Feburary 25, 2000**

SUBJECT: Code changes for the Departments of the Army, Defense, Labor, State, Transportation, and Veterans Affairs, and the U.S. Postal Service and Other Establishments, Case Management Users' Manual, Appendix 4-7

The Case Management Users' Manual is being updated and revised to reflect multiple changes, including the addition of several new codes. For the Department of the Army, new code 3335 has been added to reflect the creation of a newly separate Army Test and Evaluation Command, formerly part of an existing command. For the Department of Defense, two agencies have been renamed, and a different name has also been given to a Department of Labor agency. For the Department of State, chargeback codes 1335 and 1336 have been added to reflect injuries reported by employees of two newly created Bureaus of the Department of State. For the Department of Transportation, chargeback code 2538 has been added to reflect injuries sustained by employees of the newly created Federal Motor Carrier Safety Administration. For the Department of Veterans Affairs, chargeback code 4281 have been added to reflect injuries reported by employees of the Charleston, South Carolina Consolidated Mail Order Pharmacy (CMOP). For the U.S. Postal Service, chargeback code 5109 has been added to reflect injuries reported by employees of the Mid-Atlantic Area office. Finally, in the Other Establishments, chargeback code 1409 has been added to reflect the establishment of the Presidio Trust in San

Francisco, California, chargeback code 1492 has been added to reflect a request that U.S. Capitol Police Senate cases be listed separately from U.S. Capitol Police House cases, the listing for the U.S. Information Agency (USIA) has been replaced by a listing for the International Broadcasting Bureau (IBB) to reflect the abolition of USIA in October, 1999, and a reference to the Arms Control and Disarmament Agency has been deleted to reflect the recent abolition of that agency.

Because the procedures for adding new chargeback codes to the Case Management File have changed, ADP Systems Managers no longer need to add the chargeback codes listed below; they have been added by National Office staff. Changes in the titles for employing agencies which already exist in the agency address field will have to be added to an individual agency address.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

Trans-action type	Code	Dept.	Agency
Add	3335	Army	Test and Evaluation Command
Add	1335	State	Bureau of Arms Control & Intl Security
" "	1336	" "	Bureau for Public Diplomacy & Public Affairs
Add	2538	DOT	Federal Motor Carrier Safety Administration
Add	4281	VA	Charleston (SC) CMOP
Add	5109	USPS	Mid-Atlantic Area Office
Add	1409	Other Est	Presidio Trust
" "	1492	" "	U.S. Capitol Police - Senate
Change	3015	Defense	from: Defense Investigative Service to: Defense Security Service
" "	3016	" "	from: Defense Security Assistance Agency to: Defense Security Cooperation Agency
Change	1122	Labor	from: Office of the American Workplace to: Office of Labor-Management Standards
Change	1449	Other Est	from: U.S. Information Agency to: International Broadcasting Bureau
Change	1488	" "	from: U.S. Capitol Police To: U.S. Capitol Police - House
Delete	1483	Other Est	Arms Control and Disarmament Agency

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

Note: Immediate distribution to chargeback coding personnel is essential.

FECA CIRCULAR 00-08 **March 14, 2000**

SUBJECT: Referee Evaluations--Claims of Bias

A number of complaints of bias on the part of certain physicians selected to perform referee examinations have recently been received. Because we want to ensure a consistent, uniform response to all such complaints, we are providing this summary of existing procedures on how to handle complaints regarding OWCP selection of or use of physicians.

The FECA Procedure Manual describes the processes for responding to various types of complaints relating to medical evaluations and reports. These include: complaints concerning physical examinations (see FECA PM Ch. 3-900-14); the process for excluding medical reports from impartial medical examinations (IMEs) (see Ch. 20810-13); suspending the use of physicians in the Physician Directory System (PDS) (FECA Bulletin 00-01; issued November 5, 1999); exclusion of medical providers from payment (see 20 CFR 10.815-826 and PM Ch. 3-800). If the claimant or representative objects to the use of a particular IME physician prior to the examination and presents documented evidence of bias or unprofessional conduct on the part of that physician, see the FECA PM at Ch. 3-550-4.

Credible, reliable medical evidence is vital to the claims process and it is particularly important that OWCP-directed medical examinations are not compromised in any way. Where a complaint is received concerning a physician and/or challenging a medical report, the claims examiner should, enerally, address the complaint in the context of the specific FECA case. The CE should first evaluate the charge and supporting evidence to determine how to proceed. In evaluating any corroborating evidence, the CE may take note of such evidence as public statements made about a physician's credibility, but such evidence (such as derogatory newspaper articles or negative statements about a physician's credibility made in other forums) would not by itself be sufficient to conclude that the physician's report cannot be considered by OWCP. The mere fact that a physician's testimony has been discredited or criticized in another forum does not necessarily discredit the report by the same physician in the OWCP claim. Rather, credibility of the physician must be based on all the facts and circumstances, and the action by OWCP must follow the appropriate procedure manual sections cited above.

If OWCP receives a written complaint concerning a physician's professional conduct (which includes allegations concerning veracity, discrimination or bias) before or following an OWCP-directed medical examination, and that complaint is supported by credible evidence of the type detailed in the procedure manual, the CE may ask the DO manager or district medical director to help develop the evidence. In accordance with FECA Bulletin 00-01 (issued November 5, 1999), OWCP may provide the physician an opportunity to respond to the allegations. OWCP's determination concerning the physician must, however, be based on credible, reliable and objective evidence. Such evidence may include the findings of other

administrative bodies where the physician is a party (as opposed to a witness) in the action. Depending on the nature of the allegations, OWCP may also contact the state medical licensing agency to determine whether the physician has had his or her license suspended or revoked.

All offices should note that the memorandum from Acting Director Nancy Ricker to Robert Barnes, Chief of the Branch of Hearings and Review, dated November 3, 1999, concerning this issue is hereby rescinded. It should not be relied upon in making determinations regarding bias.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 00-09 **April 15, 2000**

SUBJECT: Compensation Payments--2000 Census

For the 2000 Census, the Bureau of the Census is employing approximately 650,000 individuals in 476 Local Census Offices (LCOs) throughout the U.S. Most of the employees in the LCOs are enumerators and crew leaders on temporary not-to-exceed 180-day appointments.

All employees are paid on an hourly basis. Wages in the Regional Census Centers and the LCOs vary by geographical area. Information about computing compensation for these employees may be found in FECA PM 2-0901.9a.

Claims staff are reminded that special procedures apply to third party injuries sustained by certain Census workers, as described in FECA Bulletin 99-30.

Any questions about pay rates may be referred to the Department of Commerce, Workers' Compensation Center, at (202) 273-3325, ext. 141 or 151.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 00-10 **May 30, 2000**

SUBJECT: Selected ECAB Decisions for July - September 1999

The attached is a group of summaries of selected ECAB decisions for the above quarter. The decision summaries are provided to point out novel issues not frequently addressed by the Board, or commonly occurring errors by the Office which need to be emphasized.

Included in this FECA Circular are summaries of a decision terminating benefits under § 8148(a); three decisions on performance of duty (one in which the issue was the application of "the personal comfort doctrine" to flexiplace working arrangements); three decisions on loss of wage-earning capacity; several decisions addressing refusal of suitable work; and others. Should you find, upon reviewing a decision summary, that it affords guidance in a topic that you are addressing, do not fail to obtain the ECAB decision in its entirety for your thorough review.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

IMPARTIAL OPINIONS - OPINION BASED ON AN INCORRECT STANDARD

George Ralston, Docket No. 97-1939, Issued July 21, 1999

The Board's decision in this claim is unusual in that they remanded the case for a fifth impartial medical opinion.

The claimed condition was a myocardial infarction. The Office denied the claim, based on the opinion of the first impartial medical examiner (IME), Dr. Turkel. The claimant appealed the decision, and the Board remanded the case for a second IME, finding that the Dr. Turkel's report was insufficiently rationalized to represent the weight of the medical opinion in the case.

The Office referred the claimant and case to a second IME, Dr. Beaver. Dr. Beaver stated that the claimant's myocardial infarction "was not caused by, precipitated by, or aggravated by his employment." He attributed the development of claimant's cardiac problems to his hypertension, gender, high cholesterol, family history, diabetes and use of tobacco. He stated that the claimant had trouble understanding the internal versus external nature of stress, and that his job demands were not unusual or excessive, but that his ability to cope with the job demands was an issue.

The Office again denied the claim, based on Dr. Beaver's report. The claimant requested an oral hearing, and stated that Dr. Beaver's report was based on an incorrect legal standard and could not represent the weight of the medical evidence. The hearing representative agreed that Dr. Beaver applied an incorrect legal standard by requiring unusual job stresses, and remanded the case for a third IME.

The Office obtained a third IME from Dr. Abovich. Dr. Abovich concluded that the claimant's risk factors of smoking, hypertension and hyperlipidemia were "overwhelmingly…more important than the stress suffered at his work although there is a possibility that work-related stress aggravated or exacerbated cardiovascular problems." The Office denied the claim based on Dr. Abovich's report.

The claimant requested a review of the written record. The hearing represented directed the Office to obtain a supplemental report from Dr. Abovich, because his opinion on causal relationship was speculative. If the supplemental report was not sufficiently clear, the Office was to obtain another IME. The Office obtained a supplemental report from Dr. Abovich, which still not clear on the issue of causal relationship, and so a fourth IME from Dr. Alagona was obtained. Dr. Alagona attributed the claimant's myocardial infarction to nonoccupational factors because his "employment status did not appear to be excessive with regard to either physical or emotional demands or concerns." The Office again denied the claim.

The claimant requested another hearing, and again asserted that the IME (this time, Dr. Alagona) based his opinion on an incorrect legal standard that his job demands be physically or emotionally excessive. The hearing representative affirmed the Office's decision, and found that

Dr. Alagona did not base his opinion on an incorrect legal standard.

The Board disagreed, and remanded the case for a fifth IME. They reiterated the principle that there is no requirement for work conditions to be unusual or excessive in order to establish compensability. If ordinary and normal working conditions cause or aggravate a condition, they are sufficient to satisfy the causal relationship test. Dr. Alagona's report suffered from the same defect as those of Drs. Beaver and Abovich.

Obtaining impartial medical opinions is a time-consuming process. When it is necessary to obtain more than one such examination, every effort should be made to ensure that subsequent IMEs do not repeat the errors of the first, and if the errors are repeated, they should not be overlooked or discounted.

LOSS OF WAGE-EARNING CAPACITY - MODIFICATION

Mildred Alder-Johnson, Docket No. 97-1972, Issued July 19, 1999

In this claim, the Office accepted low back injury and surgery as work-related. The claimant, a former distribution clerk, underwent vocational rehabilitation, earned a master's degree in social work, and obtained work as a counselor for a county agency. On July 27, 1979, the Office found that her actual earnings fairly and reasonably represented her wage-earning capacity and reduced her compensation accordingly.

The claimant received MSWR certification after a period of six years, and also obtained further training in public speaking. She opened her own private practice in 1991. On January 11, 1996, the Office modified the loss of wage-earning capacity determination to reflect no additional loss of wage-earning capacity. This decision was based on the claimant's having undergone additional rehabilitation, and her demonstrated ability to work full-time as a social worker/therapist. Because she was self-employed, the Office based the calculation of her wage-earning capacity on a labor market survey of social worker/therapists in her area, rather than her earnings.

The Board found that the case was not in posture for a decision. The Board agreed with the Office that the claimant was further vocationally rehabilitated after 1979. They also noted that she was employed in a different job, and the Office was required by its own procedures (FECA PM 2.814.11) to determine whether the new job paid at least 25 percent more than the concurrent pay of the job in which she was rated. In this case, the Office did make such a comparison, but found that the earnings in the new position did not exceed the earnings of the previous position by more than 25 percent. They then proceeded to use earnings derived from a labor market survey of similar positions. This approach is not in accordance with existing procedures. In addition, where a loss of wage-earning capacity is based on earnings from self-employment, deductions should be made from the gross earnings for direct expenses, such as cost of equipment and maintenance, insurance, taxes, wages of other employees, and other office expenses. The case was remanded for a recalculation of the claimant's adjusted actual earnings, and a determination of whether those adjusted earnings represented more than a 25 percent increase over her previous earning capacity.

LOSS OF WAGE-EARNING CAPACITY - SELF-EMPLOYMENT

Louis F. Bertoncini, Docket No. 97-2165, Issued July 12, 1999

The Board's decision in this case illustrates another instance in which a loss of wage-earning capacity based on self-employment was calculated incorrectly.

The claimant received an overpayment of compensation because he worked as a real-estate agent while continuing to receive compensation for total disability. When the Office calculated the amount of the overpayment, they used an incorrect rate of pay, and also computed the loss of wage-earning capacity based on the claimant's gross earnings from self-employment. The Board quoted from their prior decision in Thomas F. Jordan, 47 ECAB 382 (1996), stating, "A self-employed claimant has expenses associated with conducting business which must be paid from the receipts of the business. It, therefore, would be inequitable to calculate a loss of wage-earning capacity on the basis of a claimant's gross earnings from self-employment as that would not allow for the costs of conducting the business."

The case was remanded for recalculation of the overpayment.

LOSS OF WAGE-EARNING CAPACITY – MODIFICATION

Penny L. Baggett, Docket No. 97-2190, issued September 28, 1999

In the above case, the Board found that the Office's reduction of the claimant's benefits based on a Loss of Wage-earning Capacity (LWEC) was properly computed in June 1996. However, it held that modification of the LWEC in February 1997 was erroneous, as the Office had not discharged its burden of proof to take such action.

The claimant was a part-time relief rural carrier who was in a vehicle collision that resulted in an aggravation of her degenerative disc disease. Three and a half years later, the claimant returned to work as a part-time limited duty casual clerk. Five years later the claimant accepted a temporary rehabilitation position of modified casual clerk, working approximately 25 hours a week for $11.83 per hour. The Office compared the new job with her date of injury position in which she had worked 33.88 hours per week and was paid $9.36 per hour and thus obtained the claimant's loss of wage-earning capacity using the Shadrick formula (method adopted from Albert C. Shadrick, 5 ECAB 376 [1953]). The Office determined that the position fairly and reasonably represented her wage-earning capacity and reduced her benefits accordingly.

However, six months thereafter, the employing agency retroactively raised the claimant's pay rate to $16.07 per hour based upon a special exception, and asked the Office to modify its LWEC determination based on the corrected salary. On recomputation of the WEC determination, the claimant was found to have no loss of wage-earning capacity. The Board found that Office failed to discharge its burden of proof to modify the claimant's wage-earning capacity. The Board referred to a similar decision, Ronald M. Yakota,1 in which it reiterated the established conditions for modifying an LWEC:

"Once the wage-earning capacity of an injured employee is properly determined, it remains undisturbed regardless of actual earnings or lack of earnings. 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. The burden is on the Office to establish that there has been a change so as to affect the employee's capacity to earn wages in the job (previously) determined to represent his earning capacity…"

The Board explained that an increase in pay by itself, is not sufficient to support that there has been a change in the employee's capacity to earn wages. It stressed that, absent a showing of additional qualifications obtained by the employee through training, it is improper to make a new LWEC determination based on increased earnings. Furthermore, the Board pointed to the Office's own procedures which specifically provide guidelines for the Office meeting its burden for modification of a loss of wage-earning capacity.2 The Board pointed out that the Office noted that the claimant's pay rate had increased but failed to determine whether she had undergone training or vocational rehabilitation to warrant the current salary. The decision by the Office which modified the LWEC resulting in a loss of entitlement to monetary benefits was reversed by the Board.

RECONSIDERATION - TIMELINESS FOR SUSPENSIONS UNDER SECTION 8123(D)

Frank W. Manning, Docket No. 97-1505, Issued August 4, 1999

In this claim, after unsuccessful attempts to obtain updated medical information, the claimant was scheduled for a second opinion evaluation on July 1, 1994. The claimant was notified that refusal to submit to or obstruction of the examination would result in suspension of compensation until the obstruction stopped. The claimant did not go for examination, and did not respond to the notification, and the Office suspended compensation by a decision dated August 9, 1994 on the basis of the provisions of 5 U.S.C. 8123(d).

The claimant requested reconsideration by letter dated July 20, 1996, stating that he had no knowledge of the August 9, 1994 decision until July 5, 1996, when his wife notified him that they were in financial difficulty because he had not received compensation since August 1994. The claimant submitted a medical report from his physician dated July 22, 1996, and indicated that he would be willing to comply with any OWCP requests necessary to remove the obstruction. The Office denied reconsideration on the basis that the request was not timely filed, and the evidence submitted did not present clear evidence of error.

The Board found that the Office's suspension of benefits was proper, but that the Office improperly neglected to act on the claimant's willingness to comply with the direction to undergo a second opinion evaluation. Pursuant to the regulations at 20 C.F.R. 10.323, there is no time limitation on a claimant's willingness to comply with the provisions of 5 U.S.C. 8123(d). The Board vacated the Office's reconsideration decision and remanded the case so the Office could address whether compensation should be reinstated.

SUITABLE EMPLOYMENT - REFUSAL FOR RELIGIOUS REASONS

Marvin L. Wyatt, Docket No. 97-2118, Issued August 19, 1999

The claimant, who had an accepted knee condition, was receiving compensation benefits for total disability. The employer offered a job as a modified carrier, which was approved by his attending physician. The Office notified the claimant that the offered job had been found to be suitable, and was given 30 days to accept the job or provide reasons for refusing it. The claimant did not respond, and the Office subsequently terminated compensation on the basis that he refused an offer of suitable work.

The claimant's representative requested reconsideration of the termination, stating that the work hours of the offered job (9:30 p.m. to 6:00 a.m. with Wednesday and Thursday nights off) would "interfere with the practice of his religion." The claimant was a minister in his church. The Office denied the request for reconsideration on the basis that that the evidence submitted in support of the application for review was irrelevant, and therefore insufficient to warrant merit review of the prior decision.

In affirming the Office's decision, the Board reiterated the three acceptable reasons for refusing an offer of work: (1) withdrawal of the offered position; (2) medical evidence establishes that the claimant's condition has worsened to the point where he or she can no longer perform the duties of the offered job; and (3) the claimant has accepted other work that fairly and reasonably represents his or her wage-earning capacity. The Board cited two previous decisions in which religious beliefs were discounted as the basis for overturning Office decisions. In Frank Braxton McElroy, 29 ECAB 806, 812 (1978), the claimant's failure to file a timely claim was not excused by his religious belief that prayer would cure his hearing loss. In Robert Gray, 39 ECAB 1239, 1244 (1988), the claimant's inability to fulfill religious responsibilities due to a conflict with scheduled work hours was not a compensable factor of employment in a psychiatric claim.

It should also be noted that the situation in this claim differed from those in a group of decisions discussed in FECA Circular
00-4, in that the claimant did not respond to the initial notification of suitability, and so termination without providing an additional period of time for the claimant to accept the job was appropriate.

SUITABLE EMPLOYMENT - CLAIMANT ALREADY WORKING

Dorothy L. Gatson, Docket No. 99-260, Issued July 20, 1999

This claim was accepted for lumbar radiculopathy. The claimant returned to a limited-duty job for four hours per day on July 5, 1995. In November 1995, she increased her hours to five per day. In November 1996, her hours increased to six per day.

The medical evidence supported that the claimant could work six hours per day, with restrictions. On February 4, 1997, the employer offered the claimant a permanent light-duty job as a modified city carrier, six hours per day. The Office found the job suitable, and so notified the claimant, allowing 30 days for acceptance of the job or reasons for refusal.

The claimant refused the job on the basis that it would require her to continually drive and to enter and exit the vehicle. She also stated that the routes involved were not such that they allowed sitting while casing. She noted that her current position allowed her to sit with a back support while casing, and that beginning March 1, 1997, she would be able to work 8 hours per day in her current position. On February 24, 1997, her attending physician released her to work eight hours per day, with restrictions. The claimant returned to full-time work on March 8, 1997.

The Office notified the claimant that her reasons for refusing the job offer were not acceptable, and gave her an additional 15 days to accept the position. The Office subsequently terminated compensation benefits for failure to accept suitable employment. A hearing representative affirmed the Office's decision.

The Board found that the claimant had not shown that the offered job was not suitable. However, the claimant also refused the job offer on the basis that she was already working, and that she was increasing her work hours to eight per day, rather than the six noted in the job offer. The Office did not consider whether the job that the claimant was already performing represented her wage-earning capacity. Due to the Office's failure to consider this reason for refusing the job offer, termination of compensation was not justified, as the record does not establish that the claimant refused to perform suitable work. The office's decision was reversed.

REFUSAL OF SUITABLE WORK, § 8106(c) PENALTY PROVISION REVERSAL

James T. Johnson, Docket No. 99-276, issued September 24, 1999;

In this case, the Office had terminated benefits in view of the claimant's refusal to accept "suitable employment," and the decision had been affirmed by the Branch of Hearings and Review. The Board ruled that the Office had failed to discharge its burden to terminate benefits, because it had not clearly resolved the question of whether the claimant could perform the job offered in view of his work injury-related restrictions.

The case had been accepted for cervical strain, mild cerebral concussion, contusion of the scalp, and post-traumatic headache syndrome. The claimant's attending physician was not in favor of the location of the position offered due to the excessive light, noise and fumes, and the inappropriate length of the time needed to commute. A second-opinion specialist felt that the job should be tried, and that the claimant's inability to travel was subjective, and could be remedied by engaging an addiction specialist who could assist in reducing the claimant's narcotic medications. The claimant accepted the job offer in December 1993, but failed to report in January 1994 when expected to do so.

The Office reiterated its finding of suitability on May 30, 1996. Then the claimant explained that he had been hospitalized in 1994 and 1995 to accommodate the change in his medications. Since he would again be hospitalized in July 1996, his attorney proposed that the Office re-evaluate the claimant after that hospitalization. Subsequently, the Office notified the claimant that his refusal was not justified, allowed him an additional 15 days to accept the position, and then terminated compensation in October 1996. That decision was affirmed by Hearings and Review in October 1997.

The Board reversed the decisions, returning the claimant to the rolls, on the grounds that the Office had failed to meet its burden to terminate compensation. The issue was not whether the claimant had been allowed due process, but rather whether the weight of the medical evidence established that the job offered was suitable, considering the work restrictions imposed by the claimant's accepted condition.

The Board pointed out that, in view of section 8106(c) functioning as a penalty provision, barring further entitlement to compensation when an employee refuses an offer of suitable work; it should be narrowly construed. That is, the question of whether or not the claimant has refused suitable work must be clearly settled. Moreover, whether an employee has the physical ability to perform the job offered is a medical issue which must be resolved by medical evidence. Therefore, where a conflict in the medical evidence exists, the Office's burden includes resolving the conflict by referring the claimant to a qualified impartial medical specialist. On remand of the case, the Board directed that the conflict in medical opinion between the claimant's treating psychiatrist and the second opinion specialist be resolved through referral of the claimant to an appropriate impartial specialist.

TERMINATION FOR REFUSAL OF SUITABLE WORK UNDER 8106(C) AFFIRMED

Yvonne M. Gibson, Docket 99-389, issued September 27, 1999; Terry L. Edmonds, Docket 98-1970, issued September 23, 1999; Linda Musick, Docket 98-19, issued September 15, 1999; Dennis G. Merrill, Docket 97-24, issued September 16, 1999

The above cases involved situations in which the Office terminated benefits due to the claimant's refusal to accept an offer of suitable employment, and where the Board affirmed the Office's decision. In the case of Gibson, the claimant's attending physician's reports supported that she could not return to work at the Postal Service in any capacity due her inability to stand or sit for prolonged periods. The Office initially found that the second-opinion specialist's opinion outweighed that of the attending physician, and advised the claimant that the offered position was found to be suitable. When the claimant failed to accept the position within 30 days, compensation for wage loss and permanent impairment was denied. Subsequently, a hearing representative found that the second-opinion referral by the Office had resulted in a conflict in the medical evidence. The conflict was properly resolved by an examination and review of the case by a board-certified impartial specialist in Orthopedics.

The Merrill case was another in which referral to a second-opinion specialist led to a conflict in the medical evidence as to whether the claimant was capable of performing the duties of the offered position. The job offered by the employing agency was based on the restrictions outlined by the referee medical specialist that had been obtained. In both Gibson and Merrill, the Board emphasized that the question of whether an employee is physically capable of performing the job is one that must be resolved by medical evidence. In settling the question of suitability satisfactorily, the Board found that the Office had discharged its burden to terminate benefits in both of these cases.

In the Musick case, the claimant advised that she was unable to perform the duties of the modified light duty position offered due to a deterioration in her condition. The duties of the position offered were in direct correspondence to the restrictions previously outlined by the claimant's physician, and the Office advised the claimant that it was considered suitable. Also, the Office indicated that in view of the claimant having moved more than 50 miles away since her separation from her former employment, relocation expenses would be covered by OWCP. The claimant declined to accept the offer and, consequently, her benefits were terminated. When the ECAB affirmed the decision, it pointed out that the question of whether the claimant was able to perform the duties of the position was a medical one; that the claimant's statement that she could not tolerate the duties was not sufficient; and that she had failed to provide an opinion from her attending physician which supported that she could not perform the duties of the offered position. It was noted that the Office had met its burden to establish the work offered was suitable.

In Edmonds, the claimant used the medical reports of his treating osteopath to support his claims

that he was neither physically nor emotionally capable of the modified postal carrier position offered to him by his former employer. The treating physician also recommended that the claimant be treated at a pain clinic and that he participate in a work hardening program. Her reports, however, failed to adequately detail the claimant's findings upon examination or diagnostic testing, or to explain the need for work hardening or for treatment at a pain clinic. Similarly, her reports failed to establish that the claimant was physically incapable of performing the modified carrier position, which was essentially sedentary with the option to stand as necessary.

The Office relied on the opinion of a board-certified specialist in physical medicine and rehabilitation to help determine whether the claimant was physically capable of performing the job offered. The opinion of a board-certified psychiatrist was used to establish that the claimant's emotional state did not prevent him from performing the duties of the position. Even the claimant's treating psychiatrist agreed that while returning the claimant to work would increase his anger and frustration, this did not mean that he was psychiatrically disabled from performing the duties of the modified carrier position.

In all of the four decisions above, the Board ruled that the Office had discharged its burden satisfactorily by clearly settling the question of suitability, and by affording the claimant due process prior to termination of compensation.

CAUSAL RELATIONSHIP - APPORTIONMENT OF CAUSAL FACTORS

James M. Taylor, Docket No. 97-2497, Issued July 22, 1999

The Board's decision in this case serves as a reminder that in claims where both work-related and non-work-related factors are contributory, there is no requirement that the degree of disability attributable to each set of factors be delineated.

The claimant, a letter carrier, claimed a right elbow and shoulder condition, for which he required surgery on December 30, 1996. He attributed his condition to repetitive movements required case mail and deliver mail. The Office denied the claim on the basis that the evidence failed to establish that his condition was causally related to employment factors. They noted that the medical evidence did not support the relationship of the diagnosed conditions to work factors, and that the claimant had noted the onset of right shoulder pain in July after painting his entire house.

The claimant requested reconsideration, and submitted a report from his physician, Dr. Curtis. In this report, Dr. Curtis stated that when surgery was performed, he found that a chronic tear of the rotator cuff. He associated this finding with frequent use of the arm at or above shoulder level. He stated that changes found on the pathology report indicated that the process has been ongoing for a long time, and he related the changes to the claimant's casing mail at work. He stated that the condition predated the house painting in July, and that "the overuse in July 1996 simply made the discomfort refractory to conservative treatment."

The Office denied modification of prior decision, stating that the claimant sought no treatment for his condition until October 1996, which was after he painted his house. They stated that even if the claimant did have a degenerative condition of the shoulder attributable to his work, it was of no clinical significance until after he painted his house, and that the need for treatment was occasioned by the non-work factors only.

The Board found that the case was not in posture for a decision, as there was an uncontroverted inference of causal relationship, and remanded the case to seek clarification from Dr. Curtis. They stated that Dr. Curtis provided two reasons for the claimant's shoulder condition: frequent use of the arm at or above shoulder level while working; and house painting in July, 1996. Dr. Curtis did not state which of the two factors contributed to the condition more. Causal relationship does not denote a single causal factor, and does not preclude aggravation of preexisting condition by employment factors. The Office stated that Dr. Curtis noted a mix of work and non-work factors, but did not apportion the degree of contribution made by the work factors. The Board has previously held that this type of apportionment is inappropriate; if work factors contribute in any way to the development of the condition, the condition would be considered employment-related.

PERFORMANCE OF DUTY - APPLICATION OF THE PERSONAL COMFORT DOCTRINE TO FLEXIPLACE WORKING ARRANGEMENTS

Julietta M. Reynolds, Docket No. 97-695, Issued August 13, 1999

This claimant in this case was injured while working at home while under a flexiplace agreement with her employer. While she was working at home, it started getting cold, and the heat failed to come on when she adjusted the thermostat. She contacted her husband, who advised her to contact the oil company. She called the oil company and received instructions on how to restart the furnace. She then went to the basement where the furnace was located. While going back up the stairs, she fell and injured her right leg and left foot.

The employer controverted the claim on the basis that she was not in the performance of duty at the time of injury. She did not notify her supervisor when her workday was interrupted by an emergency. She was not directed to repair the furnace, and the furnace repair did not relate to her official duties or the mission of the employer.

The Office denied the claim, finding that the claimant had deviated from the course of her employment for personal reasons. A hearing representative subsequently found that the claimant's injury was covered under the personal comfort doctrine, in that she was injured while trying to raise the temperature of her work environment to a comfortable level. The Office was directed to accept the claim.

The Office Assistant Branch Chief reopened the claim under 5 U.S.C. 8128(a) and vacated the decision of the hearing representative. He noted that the personal comfort doctrine pertains to injuries that occur on the employer's premises. He further stated:

In the traditional type of workplace situation where work is performed on the employer's premises, the employer can exercise complete control of the work environment and can maintain it in a safe manner so as to reduce the likelihood of workplace injuries. One of the legal consequences of providing employment under these circumstances is the "personal comfort doctrine," which has evolved to provide coverage under workers' compensation statutes for injuries that occur on the employer's premises while the employee is ministering to his or her personal comfort instead of engaging in activities that further the employer's business.

However, some modern workplace situations, such as the flexiplace agreement by which the claimant in this case performed at least some of her work at home, are so radically different from the traditional workplace situation described above that legal concepts like the "personal comfort doctrine" cannot be fairly applied to find coverage for injuries that occur under these circumstances due to the fact that it is the employee, not the employer, who is directly responsible for maintaining the work environment in a safe manner. As such, an injury sustained while the employee is maintaining the workplace environment at home instead of performing his

or her actual work duties should not be considered the responsibility of the employer.

...the majority rule in the states is that only those injuries which occur while an employee is actually performing his or her work at home will be found to occur "in the course of employment." Accordingly, there is no flexiplace equivalent to the "personal comfort doctrine" that can be used to extend coverage under the FECA to the claimant's...injury sustained as a result of repairing her furnace at home.

The Board affirmed the rescission of the acceptance, and quoted extensively from FECA Bulletin No. 98-9, issued June 5, 1998. They found that the Office's exercise of discretion in this case, to exclude the personal comfort doctrine from flexiplace situations, did not conflict with the intent of the FECA.

PERFORMANCE OF DUTY

George Patrick Semonco, Docket No. 97-1760, issued September 22, 1999; Janet R. Landesberg, Docket No. 98-1812, issued September 10, 1999

In the Semonco decision, which the Board set aside stating it was not in posture for a decision, the claimant (a letter carrier) alleged that he had been intimidated by a postal patron and suffered an emotional condition. This patron had previously assaulted him with a gun, and the claimant had agreed to testify at the postal patron's sentencing hearing. The Office initially denied the case due the claimant's failure to timely submit requested evidence, and a subsequent decision rejected the claim for the appellant's failure to submit sufficient evidence to support his claim of intimidation.

However, the Board pointed out in its decision that the claimant's participation in the sentencing hearing constituted a specially assigned work duty arising out of his federal employment. The Board added that this case was distinct from Blondell Blassingame (48 ECAB__[Docket No. 95-2779, issued October 9, 1996]), and similar cases in which an employee's participation in EEOC proceedings will not generally afford coverage under the Act. It emphasized that such proceedings as EEOC hearings are generally for the benefit of the employee, while the legal hearing in which the claimant had participated actually provided a benefit to the employer in securing the safety of its employees while on their assigned postal routes. The Board ordered that upon return of the case to the district office, further medical development be pursued; specifically, that a Statement of Accepted Facts be prepared and the case referred to an appropriate specialist to consider the issue of causal relationship.

The Landesberg case involved a motor vehicle accident of an administrative law judge who had been authorized eight hours of official time to attend a seminar. The seminar was to be held in a city that was away from her place of employment and her weekday residence, but within commuting distance of her townhome that she owned with her husband. The employee was paying the cost for the seminar, and the employer was not reimbursing her for travel or any other expenses. The case was denied on the basis that the injury did not occur in the performance of duty, and modification was denied in two subsequent decisions.

The claimant argued that she was in a travel status from the time she left her duty station on the day before the seminar she had planned to attend. The location where the auto accident occurred was in a parking lot of a take-out restaurant in the same town as her townhome. Also, the accident occurred shortly after a brief stop at the townhome, and the day before the seminar was to take place. The Board ruled that the claimant's injury was not sustained while in the performance of duty.

The Board noted that:

"Under workers' compensation laws, an employee whose work entails travel away from the employer's premises is within the course of employment continuously during the trip, except when a distinct departure on a personal errand is shown.3 …The FECA covers an employee 24 hours a day when he or she is on a travel status, or on a temporary-duty assignment or a special mission and engaged in activities essential or incidental to such duties.4

The Board further explained that the general rule with respect to attendance at conventions, seminars and professional meetings states that compensability turns on "whether the claimant's contract of employment contemplated attendance as an incident of his work."5 It quoted Larson's Workers Compensation Law wherein it states: "It is not enough that the employer would benefit indirectly through the employee's increased knowledge and experience." The Board added that in a case where the employer required the employee to attend a seminar or conference, this would be considered probative evidence that attendance was contemplated as an incident of work.

The Board affirmed the Office's decision in this case, noting that the claimant was not in the performance of duty at the time that she was involved in the motor vehicle accident at the restaurant parking lot. However, it added that the claimant still would not have been in the performance of duty if she had actually attended the seminar. The Board emphasized that the connection of the seminar to the employment was simply not sufficient to bring the claimant's attendance at the seminar within the scope of her employment.

TERMINATION OF BENEFITS UNDER 5 U.S.C. 8148(A)

Kenneth E. Fenner, Docket No. 97-2543, Issued July 27, 1999

The Office terminated benefits in this claim pursuant to the provisions of 5 U.S.C. 8128(a), which provide:

Any individual convicted of a violation of section 1920 of title 18, or any other federal or state criminal statute relating to fraud in the application for [or] receipt of any benefit under [the Act] shall forfeit (as of the date of such conviction) any entitlement to any benefits such individual would otherwise be entitled to under [the Act] for any injury occurring on or before the date of such conviction. Such forfeiture shall be in addition to any action the Secretary may take under section 8106 or 8129.

The claimant pled guilty to a charge of theft of U.S. government funds, a violation of 18 U.S.C. 641. With the guilty plea, additional charges of fraud to obtain federal employees' compensation and false demands for payment were dropped. The claimant had altered 29 prescription receipts to show that he had paid a greater amount than he was actually charged, which resulted in an overpayment to him in the amount of $1,940.00.

The Board affirmed the Office's decision. They stated that while the violation for which the claimant was convicted was theft, rather than fraud, the facts clearly established that the theft occurred in an attempt to defraud the government, and termination of benefits as of the date of his conviction was appropriate.

The claimant also attempted to argue that he had made full restitution, and that he would suffer hardship as a result of the termination of benefits. The Board stated that the terms of 5 U.S.C. 8148(a) were clear and unambiguous, and that neither the Office nor the Board had the authority to enlarge the terms of the Act.

FECA CIRCULAR NO. 00-11 **June 30, 2000**

SUBJECT: SELECTED ECAB DECISIONS FOR OCTOBER - DECEMBER, 1999

The attached group of summaries of selected ECAB decisions is provided for study and filing by subject. Covered topics include suitable employment, performance of duty, reducing loss of wage-earning capacity to zero, claims for increased schedule awards, the effect of health benefits deductions on overpayment calculations, and timely filing based on the employer's actual knowledge.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

OVERPAYMENTS

Kenneth E. Rush, Docket No. 98-321, Issued October 6, 1999

This case involves an overpayment created due to the continuation of compensation after a return to work without wage loss. The original overpayment was calculated as the gross amount paid to the claimant during the period between the return to work and the cessation of compensation.

The Board, relying on Sandra K. Neil, 40 ECAB 924 (1989), noted that if a claimant does not derive the benefit of deductions made on his or her behalf, he or she should not be charged for those deductions. In the case at issue, the Office deducted for both health benefits and optional life insurance during the same period that the claimant's employer was doing so on his behalf. As such, the amount of the debt was found to have been calculated improperly; the debt amount should have been the net compensation received during the period in question.

This should serve as a reminder to take health benefit and optional life insurance deductions, along with the reason for the creation of the overpayment, into account when computing an overpayment.

PERFORMANCE OF DUTY

Yvonne L. McCoy, Docket No. 98-580, Issued October 14, 1999

The claimant in this case claimed to have been injured when she fell at her desk. At the time of the injury, she was suspended from her position due to conduct issues. She arrived at work despite the suspension, and was asked to leave. She left, but then returned, and the Federal Protective Service was called to escort her out. During this escort, the claimed injury occurred. The Office denied her claim as not having occurred in the performance of duty, as her presence in the workplace was in direct contravention of her suspension.

The Board affirmed this denial, finding that Ms. McCoy's presence at the workplace was "not for the fulfillment of her employment duties." The Board also found that the refusal to leave until the Federal Protective Service was called was misconduct (although not of the level of statutorily willful misconduct).

PERFORMANCE OF DUTY - FACTORS OF EMPLOYMENT

Ylanda Y. Dugay, Docket No. 97-1912, Issued December 2, 1999

The employee filed an occupational disease claim for sleep dysfunction and stress due to working at night. She had been working on the night shift (12:50 am to 9:00 am) for ten years, and found that she was increasingly tired, forgetful, unable to meet deadlines, nervous, and depressed. She did not request a change of shift. Considerable medical evidence was submitted to support that working the night shift caused her condition. The Office denied the claim, finding that she failed to establish a compensable factor of employment, and her condition was not sustained in the performance of duty.

The Board found that the case was not in posture for a decision, and remanded the case for preparation of a statement of accepted facts and further development of the medical evidence. The Board noted, "Compensability does not arise with frustration over not being able to work in a particular environment, but rather it arises from performance of regular or specially assigned duties." The employee's working the night shift constituted a compensable employment factor, because such work related to the performance of her regular duties.

PERFORMANCE OF DUTY - PERSONAL ERRAND

Amy Ureel, claiming as widow of Michael Ureel, Docket No. 97-1752, Issued December 28, 1999

The employee in this decision was killed in a motor vehicle accident. He and a co-worker had worked at one employer location, Slocum Annex, during the morning, and were instructed to return back to the main post office, located two and one-half miles away. As the two employees left Slocum Annex, Mr. Ureel stated his intent to stop at his apartment to pick up a leave slip. The apartment was located off of Grand River Avenue. Mr. Ureel stopped at his apartment and retrieved the leave slip. As his vehicle was leaving the private street where the apartment complex was located and turning on to Grand River Avenue, a westbound motorist struck his vehicle, and he was killed. There was no finding as to whether the employee was attempting to turn left or right. The Office denied the claim on the basis that the employee deviated from his main business route to attend to a personal errand, and had not regained the main business route at the time of the accident, and was therefore not in the performance of duty.

Initially, the Board considered whether the employee was on a personal errand or not at the time of injury. The employee's retrieving a leave slip did not further the employer's business, and was of benefit to the employee, not the employer, and was therefore personal in nature. The Board also considered whether the deviation in this instance would be considered insubstantial, such as momentary diversions needed to administer to one's personal comfort. The Board found that the deviation in this case did not minister to a personal comfort need.

The Board then considered whether, at the time of the accident, the employee had completed his personal errand and resumed his business route. Testimony and statements from coworkers indicated that there were several possible reasonable routes between the two work sites. The employer did not direct employees to take one specific route. A review of a map of the area revealed that there were several possible routes that involved travelling on Grand River Avenue.

The employee apparently left the Slocum Annex and traveled west on Grand River Avenue, passing Drake Road, then turning right into the private drive that led to his apartment complex. The Director argued that the point of deviation from the business route was the intersection of Grand River Avenue and Drake Road. This was based in part on an observation that the employee was attempting to turn left (east) onto Grand River Avenue at the time of the accident, and must have been returning to Drake Road to resume the business route. The Board found, however, that the location where the accident occurred on Grand Avenue was part of an accepted business route between Slocum Annex and the main post office. Whether he intended to turn right or left onto Grand River Avenue did not matter, because the personal deviation ceased as soon as he entered Grand River Avenue. The Office's decision was reversed.

PERFORMANCE OF DUTY - PREMISES

Denise A. Curry, Docket No. 97-2579, Issued November 3, 1999

The claimant in this decision was injured when she slipped and fell on a sidewalk adjacent to the employer's premises, just prior to her usual starting time. The sidewalk was snow-covered, and was a public city-owned sidewalk. Under local ordinances, the owner or person in possession of the property abutting a public sidewalk was liable for any injury caused by the presence of ice or snow. The Office denied the claim as not having occurred in the performance of duty.

An Office hearing representative found that the sidewalk on which the claimant fell was not reserved exclusively or even primarily for employees of the employing establishment, and that responsibility for snow removal did not confer ownership or control of the sidewalk to the employer, or the status of premises upon the sidewalk. In subsequent requests for reconsideration, the claimant's attorney argued that employees of the employing agency removed snow from the sidewalk, and that town code required timely removal of snow and ice. Modification of the prior decision was denied.

The Board affirmed the Office's decisions. They found that the injury took place on a public sidewalk, and was not part of the employer's premises. The proximity rule did not apply in this instance, because the ice and snow were a hazard common to anyone using the sidewalk, and not specifically related to the employment. The Board also noted that the employer's responsibility to clear the sidewalk might subject the agency to tort liability under the Federal Tort Claims Act.

REFUSAL OF SUITABLE WORK

Ronald B. Jackson, Docket No. 97-2524, Issued December 13, 1999

The employee in this decision was a postal clerk who sustained a back injury. After several periods of intermittent leave, return to light duty, and recurrences, he began to work as a part-time community service officer at $8.00 per hour, at a location within a few minutes of his home. Prior to his paid employment, he performed volunteer work for the same employer.

The Federal employing establishment offered the employee a full-time modified rehabilitation clerk position. The employee refused the job, stating that it would require a ninety-minute commute each way. The office found that the job was suitable and so informed the employee. The employee again refused the job, stating that the commute was too long, and that his current job, in which he performed similar duties, was only four and one-half minutes from his home. After giving the employee an additional 15 days within which to accept the position, the Office terminated compensation for failure to accept suitable work, finding that the job he currently held did not represent his wage-earning capacity because he would earn more from the offered position.

The Board found that the Office had improperly found that the employee refused suitable work. If an employee already has a job at the time the Federal employer offers another job, the office must first consider whether the actual earnings fairly and reasonably represent the individual's wage-earning capacity. This determination must be based on full consideration of all the factors involved in the particular case. In this instance, the only reason offered for finding that the employee's actual earnings did not represent his wage-earning capacity was that he would receive higher wages in the offered position. The mere fact that a higher-paying position is offered does not mean that an employee has a higher wage-earning capacity. Actual earnings in a job in the private sector cannot be compared with earnings from an offered federal job. The Office must consider whether the actual earnings fairly and reasonable represent what the claimant could be expected to earn in the general labor market in the commuting area. The Office did not conduct an open labor market survey prior to finding that the actual job did not represent the employee's wage-earning capacity, and the Board reversed their decision.

REFUSAL TO ACCEPT SUITABLE EMPLOYMENT - RELOCATION

Oliver E. Chambers, Docket No. 99-683, Issued November 4, 1999

The issue in this claim was whether the claimant refused an offer of suitable work. The claimant, an MSHA safety specialist who lived in Tennessee, sustained a work-related back injury in 1986. In 1996, the claimant's attending Board-certified orthopedic surgeon released him for work, with certain physical restrictions.

The employer offered him a job as a mine safety health specialist, in Birmingham, Alabama, with relocation expenses. The claimant refused the job, stating that he was not physically capable of performing the job. The Office found the job suitable, and informed him that he had 30 days to accept the job offer or explain why he refused it. When the claimant did not respond, the Office terminated monetary compensation for refusing an offer of suitable work.

The claimant requested a hearing, and submitted notes from his physician stating that the physician had left the number of hours the claimant was able to work per day blank, and that the claimant could perform the offered job at a local office, but was not able to drive a car for any length of time, or travel to other states. The hearing representative affirmed the Office's decision.

The Board also affirmed the Office's decision, finding that the physical requirements of the offered job were in accordance with the attending physician's restrictions. Although the claimant preferred not to relocate to Birmingham, Alabama, he was still being carried on the employing agency's rolls, and thus the agency was required to find him suitable work. He was not justified in refusing the job offer, which included relocation expenses.

REHABILITATION - REDUCTION TO ZERO FOR FAILURE TO COOPERATE

Jacquelyn V. Pearsall, Docket No. 98-111, Issued December 6, 1999
Kenneth A. Watson, Docket No. 98-763, Issued December 17, 1999

In both of these decisions, the Board reversed the Office's decision to reduce compensation to zero based on the employee's failure to cooperate with vocational rehabilitation efforts without good cause.

In Pearsall, the employee actively participated in the rehabilitation process from 1994 through 1996, when services were interrupted due to the need for post-surgical therapy. In 1997, the attending physician released the employee for work, with restrictions, and rehabilitation efforts were resumed. Vocational testing had been performed previously, and job categories were identified which were appropriate for the employee and available in her geographic area.

The employee refused to resume rehabilitation efforts due to back pain, even though the medical evidence supported her ability to work. After advising her that her compensation would be reduced to zero for failure to cooperate with the rehabilitation effort, the Office terminated compensation. A subsequent review of the written record resulted in an affirmation of the Office's decision.

The Board found that the Office improperly reduced the employee's compensation to zero. Section 8113(b) of the FECA provides for reduction of monetary compensation in accordance with what would have been the wage-earning capacity if an individual does not cooperate in the rehabilitation effort. The Regulations in effect at the time of the Office's decision state at 20 CFR 10.124(f), in part:

> If an employee without good cause fails or refuses to apply for, undergo, participate in, or continue participation in the early but necessary stages of a vocational rehabilitation effort (i.e., interviews, testing, counseling, and work evaluations), the Office cannot determine what would have been the employee's wage-earning capacity had there not been such failure or refusal. It will be assumed, therefore, in the absence of evidence to the contrary, that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity and the Office will reduce the employee's monetary compensation accordingly.

The Office erred in assuming a loss of wage-earning capacity of zero, because the claimant's refusal to participate did not occur in the early stages of rehabilitation. She had participated in testing and counseling, and appropriate jobs had been identified. The Office had sufficient information to determine her wage-earning capacity, and was not justified in assuming a zero loss of wage-earning capacity.

In Watson, the employee met with his rehabilitation counselor, underwent testing, and

cooperated to the extent that an appropriate job training opportunity was identified. As in Pearsall, the assumption of a zero loss of wage-earning capacity could not be made because the employee did cooperate in the early states of vocational rehabilitation. Rather, in both of these cases, a loss of wage-earning capacity should have been established based on the identified positions, which may or may not have resulted in a reduction to zero.

SCHEDULE AWARD--CLAIM FOR INCREASE

Linda T. Brown, Docket No. 98-498, Issued October 1, 1999

The claimant in this case was denied a schedule award in August of 1995 due to a lack of ratable impairment. On September 2, 1997, she requested that the office reconsider; she also submitted a new medical report from her treating physician noting both that her condition had stabilized and that she had a permanent impairment. The Office denied her request for reconsideration as untimely and without clear evidence of error.

The Board, citing Paul R. Reedy, 45 ECAB 488 (1994), found that this denial of the request for reconsideration was not correct because she was not truly requesting reconsideration of the 1995 decision. All of the new information provided noted her current (1997) condition, not her condition at the time of the decision. The Board found that the claimant was really requesting an increased schedule award, and was entitled to a decision regarding that request.

Claims staff should note this decision when considering reconsideration requests on schedule awards.

TIMELY FILING - TREATMENT AT EMPLOYEE ASSISTANCE PROGRAM

Delmont L. Thompson, Docket No. 97-988, Issued November 1, 1999

In this decision, the claimant filed a claim on March 16, 1996 for depression, panic anxiety, and memory loss that he first realized was related to his employment on November 15, 1990. He attributed his condition to harassment by his supervisor (and a coworker), who first referred him to the Civilian Employee Assistance Program (CEAP) in 1988. He retired on November 30, 1990, but continued to work as a reemployed annuitant through January 18, 1991. The Office denied the claim as not timely filed within three years of the last exposure, or when the claimant should reasonably been aware of a relationship between his employment and his condition.

The claimant made an argument that the employer had actual knowledge of his condition, because he was referred to the CEAP in 1988. In prior decisions, the Board has noted that when a claimant seeks treatment at an employing agency health unit, the supervisor is deemed to have actual knowledge of the injury as of the date of treatment. In this instance, however, the claimant sought treatment with CEAP, which is not under control of the employing agency, and does not make treatment records available to the employer, unlike a health unit. Therefore his treatment with CEAP did not confer actual knowledge of his injury upon his supervisor. The Board affirmed the Office's decision.

FECA CIRCULAR NO. 00-12 **July 20, 2000**

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

The interest rate to be assessed for the prompt payment bills is 7.25 percent for the period July 1, 2000 through December 31, 2000.

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

The rate for assessing interest charges on debts due the Government has not changed. The rate of 5 percent continues to be in effect through December 31, 2000.

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

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

7/1/00 - 12/31/00	7.25%
1/1/00 - 6/30/00	6.75%
7/1/99 - 12/31/99	6.5%
1/1/99 - 6/30/99	5.0%
7/1/98 - 12/31/98	6.0%
1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

DMS INTEREST RATES

1/1/00 - 12/31/00	5%
1/1/99 - 12/31/99	5%
1/1/98 - 12/31/98	5%
1/1/97 - 12/31/97	5%
1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%
1/1/95 - 6/30/95	3%
1/1/94 - 12/31/94	3%
1/1/93 - 12/31/93	4%
1/1/92 - 12/31/92	6%
1/1/91 - 12/31/91	8%
1/1/90 - 12/31/90	9%
1/1/89 - 12/31/89	7%
1/1/88 - 12/31/88	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%
Prior to 1/1/84	not applicable

FECA CIRCULAR NO. 00-13 **August 9, 2000**

SUBJECT:DUAL BENEFITS – AUTHORIZATION AND EARNINGSINFORMATION FROM SOCIAL SECURITY ADMINISTRATION

Effective immediately, Forms CA-936 and CA-1036 are obsolete. Their use is replaced by new Form SSA-581, which is now required by the Social Security Administration for use in obtaining social security detailed earnings information. Form CA-935 has been revised to accommodate the use of this form. A copy of the revised CA-935 and new SSA-581 are attached for your reference.

The system will automatically enter the claimant's name, Social Security Number, Date of Birth, Date of Death (if applicable), the claims examiner's telephone and FAX numbers, and the claimant's address, telephone number and Social Security Number. As is currently done with Form CA-936, the claims examiner then enters the period requested and forwards 2 copies of the SSA-581 to the claimant. The claimant then makes any necessary corrections and signs and dates both copies of the SSA-581. Upon receipt of the two signed forms, the claims examiner then forwards one copy to the Social Security Administration, and retains the other copy in the case file, as is currently done with Form CA-1036.

There is no change in procedures. The only change is that the SSA-581 replaces both the CA-936 and CA-1036.

This form is not used for requests for SSA FERS dual benefits. For these requests, continue to use the FERS SSA Dual Benefits Calculations FAX Transmittal.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

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

Dear CLAIMANT NAME:

This is a request for certain information concerning any wages you may have earned during the period <01/01/1901> to <01/01/1901>.

Therefore, please do the following:

1. Review the information that is pre-printed on the two copies of Form SSA-581 enclosed. Correct any preprinted information by drawing a line through the incorrect information and writing the correct information above it. Be sure to correct both copies of the form.

2. Add any other last name ever used by you or the deceased (if applicable) on the appropriate line on both copies of the form.

3. Sign and date both copies of the form.

4. Please return BOTH copies of the completed form to the OWCP District Office address noted at the top right side of the form within 30 days. DO NOT SEND THE FORMS TO THE SOCIAL SECURITY ADMINISTRATION.

Sincerely,

NAME OF SIGNER
TITLE

Enclosure: SSA-581

Attachment Form SSA-581

FECA TRANSMITTALS (FT)--INDEX

FT 00-01 New Chapter 5-0207, BPS Reports (01/00A)

FT 00-02 New Part 1 - Mail and Files (02/00A)

FT 00-03 New Chapter 2-0300, Communications, and revised Chapter 2-0400, File Maintenance and Management (02/00A)

FT 00-05 Revision to Chapter 0-0100, Introduction to FECA and DFEC (02/00A)

FT 00-06 Revision to Chapter 2-1000, Dual Benefits (02/00A)

FT 00-07 Revision to Chapters 3-300, Authorizing Examination and Treatment, and 3-400, Medical Services and Supplies (08/00A)

FT 00-08 Revision to Chapters 2-805, Causal Relationship, and 2-810, Developing and Evaluating Medical Evidence (08/00A)

FT 00-09 Revision to Chapters 2-700, Death Claims, and 2-901, Computing Compensation (09/00B)

FT 00-10 Revision to Chapters 2-200, General Provisions of the FECA, and 2-812, Periodic Review of Disability Cases (08/00B)

FT 00-11 Revision to Chapters 2-807, Continuation of Pay, and 2-1500, Recurrences (09/00A)

FECA TRANSMITTALS (FT)--TEXT

FECA TRANSMITTAL NO. 00-01 **January 6, 2000**

RELEASE - NEW CHAPTER 5-0207, BPS REPORTS, PART 5 - BENEFIT PAYMENTS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

New Chapter 5-0207, BPS Reports, replaces and updates Chapter 5-1001. The Outline for Part 5 is updated to reflect this change, and the removal of Chapter 5-1002, which was previously replaced by Chapters 5-0201, BPS FECS001 Programs, and 5-0202, BPS Jobs.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages Insert New Pages

Part	Chapter	Pages	Part	Chapter	Pages
5	Outline		5	Outline	
5	5-1001	All	5	5-207	i 1-12

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

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

FECA TRANSMITTAL NO. 00-02 **February 10, 2000**

RELEASE - NEW PART 1 - MAIL AND FILES, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

These chapters replace Part 1 - Communications and Records. The topics are much the same as those covered in the previous Part 1. However, material more relevant to claims staff (e.g., how to prepare correspondence), now appears in new PM 2-0300, Communications, and revised PM 2-0400, File Maintenance and Management.

This revision does not address imaging of case files. We will be issuing an Operations Manual with instructions about the imaging process for use by each office as it "goes live" with imaging. That document will be structured much like Part 1, and after the processes it describes have been refined in light of experience, its contents will be incorporated into Part 1.

The new Part 1 chapters include the following:

Chapter 1-0100, Introduction--the responsibilities of various parties for the district office's mail and file operation, and the structure of Part 1.

Chapter 1-0200, Jurisdiction--the jurisdictions of the various district offices.

Chapter 1-0300, Processing Mail--the kinds of mail received and how to handle them. This chapter also addresses sorting and recording mail, as well as how to process cash received and how to process outgoing mail.

Chapter 1-0400, Creation of Cases--the contents of new cases and how to create them.

Chapter 1-0500, Maintenance of Cases--how to maintain case files, including dividing files and doubling cases. The chapter also addresses how to send cases out of the office and process them on return.

Chapter 1-0600, Transfer, Loan, and Retirement of Cases--describes how to send files from one office to another. The chapter also addresses retirement of closed files to the Federal Records Center (FRC), and handling of cases recalled from the FRC. The OWCP Records Disposal Schedules are currently under revision. When they are issued in final form, the portion which addresses retention of FECA claim files will be added to this chapter as an exhibit.

While the automated system is referenced in various places, the basic resources for keying instructions and data management are the Users Manuals for the various subsystems.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
1	---------------		1	List of Chapters	
	1-100	i, 1-10 Exs. 1-2		1-0100	i, 1-2 Ex. 1
	1-200	i, 1-9 Exs. 1-4		1-0200	i, 1-6 Ex. 1
	1-201	i, 1-14 Exs. 1-2		1-0300	i, 1-11 Ex. 1
	1-300	i, 1-6 Exs. 1-3		1-0400	i, 1-7 Ex. 1
	1-400	i, 1-8		1-0500	i, 1-6
	1-500	i, 1-9		1-0600	i, 1-5 Ex. 1
	1-501	i, 1-7			
	1-502	i, 1 Ex. 1			
	1-600	i, 1-13 Exs. 1-5			

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

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

FECA TRANSMITTAL NO. 00-03 **February 10, 2000**

RELEASE - NEW CHAPTER 2-0300, COMMUNICATIONS, AND REVISED CHAPTER 2-0400, FILE MAINTENANCE AND MANAGEMENT, PART 2- CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

A new PM Chapter 2-0300, Communications, is issued with this transmittal. It includes material on priority correspondence which previously appeared in the previous PM Part 1 - Communications and Records, and two paragraphs on providing copies of correspondence to employing agencies and employees' representatives which formerly appeared in PM 2-0400. It also contains material originally published in FECA Bulletin 92-20 about providing responses to controlled correspondence received in the National Office.

PM 2-0400 has been revised and updated so that the material it contains corresponds to the newly revised FECA PM Part 1 - Mail and Files. As with Part 1, this chapter does not address imaging, which will be discussed in a separate Operations Manual. This chapter will be revised to include procedures for imaging after the program gains experience with this process. Finally, the paragraph addressing standards for timeliness of case actions has been moved to PM 0-0100, as the standards apply to the program as a whole and not just to claims personnel.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	List of Chapters		2	List of Chapters	
------	-----			2-0300	i, 1-7
	2-0400	i, 1-11		2-0400	i, 1-10

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

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

FECA TRANSMITTAL NO. 00-05 **March 3, 2000**

RELEASE - REVISION TO CHAPTER 0-0100, INTRODUCTION TO FECA AND DFEC, PART 0 - OVERVIEW, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

New paragraph 5 has been added to PM 0-0100 to address standards for timeliness of case actions. A shorter version of this paragraph formerly appeared in PM 2-0400. The material about training now appears in paragraph 6.

Minor changes have been made to paragraphs 3, 4a(1) and (2), and 6a, b, and c, and the entire chapter has been repaginated. Finally, Exhibit 2 has been updated to show the current telephone and fax numbers for the Branch of Hearings and Review.

DENNIS M. MANKIN
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
0	0-0100	i, 1-6 Ex. 2	0	0-0100	i, 1-7 Ex. 2

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

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

FECA TRANSMITTAL NO. 00-06 **January 14, 2000**

RELEASE – REVISION TO CHAPTER 2-1000, DUAL BENEFITS, PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

The list of staff members at OPM who may be contacted about dual benefits issues has been revised.

Dennis M. Mankin
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1000	Ex. 2	2	2-1000	Ex. 2

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

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

FECA TRANSMITTAL NO. 00-07 **June 30, 2000**

RELEASE - REVISION TO CHAPTERS 3-300, AUTHORIZING EXAMINATION AND TREATMENT, AND 3-400, MEDICAL SERVICES AND SUPPLIES, PART 3 - MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 3-300, paragraph 6c is revised to reflect the fact that an employee need not consult OWCP for approval when the physician initially selected refers the employee to an appropriate specialist.

A phrase referring to attendant services is removed from Chapter 3-400, paragraph 6a to reduce confusion.

These changes are related to the 1999 revisions to the Regulations.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
3	3-300	i,5-6	3	3-300	i,5-6
	3-400	i,9-10	3	3-400	i,9-10

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

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

FECA TRANSMITTAL NO. 00-08 **July 12, 2000**

RELEASE - REVISION TO CHAPTERS 2-805, CAUSAL RELATIONSHIP, AND 2-810, DEVELOPING AND EVALUATING MEDICAL EVIDENCE, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-805 and 2-810 are revised to reflect provisions of the revised Regulations as discussed in Bulletin 99-13.

20 CFR 10.311 allows the acceptance of a diagnosis of subluxation from a chiropractor without review of the actual x-rays or x-ray report. Chapter 2-805, paragraph 3a is revised accordingly.

20 CFR 10.323 provides that 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 obstructed a required medical examination. This revision is reflected in Chapter 2-810, paragraph 14.

Chapter 2-810, paragraph 15 is revised to include the fact that OWCP will not approve an elaborate service or appliance where a more basic one is suitable.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-805	i,3-4	2	2-805	i,3-4
	2-810	i,29-32	2	2-810	i,29-32

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

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

FECA TRANSMITTAL NO. 00-09 **July 28, 2000**

RELEASE - REVISION TO CHAPTERS 2-700, DEATH CLAIMS, AND 2-901, COMPUTING COMPENSATION, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-901 has been substantially revised. Former Paragraph 13 has been renumbered paragraph 19, and revised to incorporate the procedures for processing claims for leave buy back discussed in FECA Bulletin 96-11. Paragraph 13 is now reserved. Exhibit 4 has been removed. Paragraph 18 has been expanded to include the criteria for approving a representative payee. This information was previously found in the Regulations prior to the recent revision. Paragraph 11 is revised to include the fact that the maximum pay rate does not apply to compensation paid due to an assault which occurred during an attempted or actual assassination of a Federal official.

Chapter 2-700, paragraph 8 is revised to include the fact that student status should be verified twice each year.

These revisions incorporate the information provided in FECA Bulletin 99-11.

DEBORAH B. SANFORD

Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-700	i 9-12	2	2-700	i 9-12
	2-901	i 15-20 27 Ex 4	2	2-901	i 15-20 27-32

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

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

FECA TRANSMITTAL NO. 00-10 **August 9, 2000**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-200, paragraph 2, and 2-812, paragraph 8, are revised to reflect provisions of the revised Regulations regarding payment of an attendant allowance discussed in FECA Bulletin 99-09. (The first part of paragraph 9 has been reformatted, but the contents have not changed.)

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-200	i 1-2	2	2-200	i 1-2
	2-812	i 7-12	2	2-812	i 7-12

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

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

RELEASE -REVISION TO CHAPTERS 2-807, CONTINUATION OF PAY, AND 2-1500, RECURRENCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 00-11 **July 31, 2000**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-807 and 2-1500 are revised to reflect provisions of the revised Regulations regarding COP entitlement found in FECA Bulletin 99-06. Specific changes appear in 2-807 paragraphs 4a, 6a, 6c, 7a, 7b, 8d, 9g, 11, 12b, 13, 14a, 14b, 14d, former 15e (deleted) and former 15f (renumbered 15e) and 16a. (Paragraph 2-807.11, as it refers to FLSA for firefighters, has not been revised at this time. FECA Bulletin 00-05 provides current guidance on this.) Chapter 2-1500, page 9 was reformatted to remove some duplicate text.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-807	i,1-10 13-18	2	2-807	i, 1-10 13-18
	2-1500	i, 9-10	2	2-1500	i, 9

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

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

OWCP BULLETINS (OB)--INDEX

OWCP BULLETINS (OB)--TEXT

OWCP CIRCULARS (OC)--INDEX

OC 00-01 Reimbursement Rates for Travel (02/00A)

OWCP CIRCULARS (OC)--TEXT

OWCP CIRCULAR NO. 00-01 **January 25, 2000**

SUBJECT: Reimbursement Rates for Travel

Effective January 14, 2000 the mileage rate for reimbursement to federal employees traveling on official duty by privately-owned automobiles is increased to 32.5 cents per mile by the General Services Administration. The rates for travel by motorcycle and airplane are not affected. As in the past, these rates have been made to apply to injured workers (IWs) involved in approved rehabilitation activities (under the maintenance allowance and prior-authorized travel to and from a residential facility), rehabilitation counselors (RCs) under the OWCP-35 and specific authorization by the rehabilitation specialist (RS) under the OWCP-16 and OWCP-24, and contract field nurses (FNs) under the supervision and management of the staff registered nurses (SRNs).

Effective immediately all IWs, RCs, and FNs should be advised of the new rates in effect and date of applicability. Appropriate measures should be undertaken to allow for adjustment of the mileage requests from IWs, who traveled to and/or from residential facilities under RS approval and RCs and FNs during the course of their usual work when requested in writing if undertaken before they could be notified of this change.

The rates were posted in the Federal Register Amendment 88, January 7, 2000.

Cecily A. Rayburn
Acting Director, Division of
Planning, Policy and Standards

List No. 5 All FECA and LHWCA Claims Examiners, Supervisors, Rehabilitation Specialists, Systems Managers, Technical Advisors, and FECA Staff Nurses

OWCP TRANSMITTALS (OT)--INDEX

OWCP TRANSMITTALS (OT)--TEXT