BCT-FY01

This infobase contains a numerical index of all **FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 2001**, as well as the text of these issuances.

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

FECA BULLETINS (FB)--INDEX

FECA BULLETINS (FB)--TEXT

FECA BULLETIN NO. 01-01

Issue Date: October 25, 2000

Expiration Date: October 24, 2001

Subject: Bill Payment/BPS - "Real-Time" Pharmacy

Background: Since the summer of 1998, DFEC has been receiving and processing bills received via electronic data interchange (EDI). Since that time, the proportion of direct pharmacy billing has increased, and approximately 50 percent of all pharmacy bills are now received via EDI.

A new service is being offered to pharmacies effective October 23, 2000. "Real-time" pharmacy bill processing will allow pharmacies, through a clearinghouse intermediary, to enter information concerning a pharmacy bill on their point of sale device and receive a rapid response from OWCP as to whether the bill is payable, and the amount payable. If the bill is payable, the claim will be captured and processed by OWCP.

Reference: FECA Bulletin 98-11.

Purpose: To notify District Offices of an enhancement to the bill processing system.

Applicability: All staff.

Actions:

1. DFEC will receive and process "real-time" electronic bills from pharmacies for prescription drugs, through intermediary clearinghouses. Through a secure communications link, pharmacies will be able to submit bills to a central location in the National Office. The bills will undergo editing that essentially mirrors the editing performed by the bill edit program (BILL552), and the pharmacy will receive an immediate (on-line) response as to the payability of the bill.

2. If the bill is determined to be payable, the amount payable under the fee schedule will be calculated, and the pharmacy (through the clearinghouse) will receive a message that the bill is approved, and the amount payable.

3. If the bill is not payable, the pharmacy (through the clearinghouse) will receive a message that the bill is not payable, and the reason. After that, the pharmacy may submit the bill to OWCP through the regular EDI process, or submit the bill in paper form for routine processing by the district office.
4. The payable bills will be transmitted to the appropriate district office for processing. "Real-time" bills will be loaded automatically via BILL516.

5. A batch number assignment scheme similar to that devised for EDI pharmacy bills has been developed for "real-time" pharmacy bills, as follows:

The first three characters will be EDR
The fourth character is a letter from A to L, which
represents month 01-12.
The fifth character is a letter from A to Z, or number
between 1 and 5, which represents the day of the month.
The sixth character is a letter between A and Z which
represents the number of batches between 01 and 26.

6. The "real-time" bills will be loaded with a bill total equal to the sum of the payable amounts for each line item. The line item amount will be the actual amount billed by the pharmacy. If the payable amount for the line (due to the application of the fee schedule) is less than the billed amount, an ineligible amount equal to the difference between the two will be loaded, with an ineligible amount code of I. If the payable amount equals or exceeds the billed amount, these two fields will be blank.

7. All "real-time" bills will be loaded with an appeal code of B, so that the fee schedule is bypassed. Reapplication of the fee schedule is not needed, since it will have been applied already during National Office processing.

8. Once the EDR bills are loaded into the bill tables on the Sequent, they will be edited by a modified version of the bill edit program, which applies only duplicate (edits 801-805) and restricted/excluded provider (edits 201, 202) edits. No new edits are required for "real-time" bills.

9. BILL552 reports will be produced for the EDR batches (along with other bills). The number of suspended "real-time" bills should be minimal. Any bills that do suspend will require resolution, in accordance with existing procedures.

10. As with the EDI pharmacy bills, because the "real-time" bills are submitted electronically, ability to change the data in bill resolution is very limited. The only data field which may be accessed in bill resolution is the bypass code.

11. As with EDI pharmacy bills, the addresses for "real-time" pharmacy bills are obtained from

a central location, rather than the district office provider file. The address sequence number will be FD, and claimant reimbursements will not be allowed.

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)

FECA BULLETIN NO. 01-02

Issue Date: November 15, 2000

Expiration Date: November 14, 2001

Subject: Bill Payment/BPS - Modifications to Inpatient Hospital Bill Procedures

Background: A fee schedule for inpatient hospital bills, based on the Medicare system of Diagnosis-Related Groups (DRGs), was implemented January 4, 1999. Since then, inpatient hospital bills have been data entered using special software on a stand-alone computer. Bills processed as inpatient bills have been limited to those containing certain codes in the Locator-4 position on the UB-92 billing form.

Through processing inpatient hospital bills, we have found that there are various categories of inpatient bills that could not be processed accurately through the existing mechanism and/or required extensive manual handling by District Office staff. These categories include interim bills, bills from intermediate care units within hospitals (skilled nursing facilities), and short stay (1 day) bills.

In addition, because of the unique characteristics of bills processed under FECA, and the relatively small number of such bills when compared to the Medicare system, adjustments are being made to the payment calculation algorithms. The maximum amount payable for any inpatient bill will be limited to no more than 120% of the billed amount. Allowable charges for stays of less than 24 hours will be calculated based on the applicable cost-to-charge ratio for the state in which the hospitalization took place.

Allowable fees for the new categories of bills (interim and skilled nursing facility bills) will also be processed using a cost-to-charge ratio.

The above changes will be applicable to all inpatient bills regardless of dates of service. However, it should be noted that the pricing factors are updated annually by the Health Care Financing Administration (HCFA) effective October 1 of each year. The date of discharge is used to determine which year's pricing factors are applied to a particular bill, and only five year's worth of pricing data is maintained.

Reference: FECA Bulletins 99-21 and 99-31; Federal (FECA) Procedure Manual, Chapter 5-203, Exhibit 1.

Purpose: To notify District Offices of revised procedures for processing inpatient hospital bills.
Applicability: All staff.

Actions:

1. Effective November 15, 2000, the parameters for separating inpatient from outpatient bills are as follows:

    a. The first digit of the code in form locator 4 must be 1, 2, 4, 6, or 8; the second digit 1, 2, 5, 6, 7 or 8; and the third digit 1, 2, 3, 4 or 7; and

    b. Room and board charges are present on the bill. Such charges are shown with RCCs of 100 through 169.

2. Hospital bills meeting the above guidelines will be forwarded to the National Office in accordance with FECA Bulletin 99-31 for data entry.

3. The FECS001 "Bill Input" program has been modified to block data entry of the additional inpatient hospital locator 4 codes, as described above.

4. If a hospital appeals fee reductions on interim bills, the allowable fee for the entire hospitalization may be recalculated once the patient is discharged, and the admit through discharge bill is provided. The total sum of the previously paid amounts should be shown as a prior paid amount in Locator-54 on the UB-92 form.

Training on these procedures 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)

FECA BULLETIN NO. 01-03

Issue Date: December 26, 2000

Expiration Date: December 25, 2001

Subject: Bill Payment/BPS – Prior Authorization for Pharmacy

Background: Currently DFEC receives and processes pharmacy bills via electronic data interchange (EDI) and in paper form for routine processing by the district office. Recently, "Real-Time" processing was implemented (see FECA bulletin 01-01) as a service to pharmacies that allows them to know immediately if a medication is payable. This service will result in an increase in EDI bills since many pharmacies would not use the previous batch process without assurance of payment. Because "Real-Time" pharmacy bills are edited at a central location, bills that formerly would have suspended at the district office are now rejected in the "Real-Time" process. In order to allow offices to record their decisions on these bills, so that a greater proportion of pharmacy bills in both the "Real-Time" and other processes may be processed without suspension or rejection, a prior authorization function for pharmacy has been developed. The new desktop application will allow Claims Examiners to authorize or deny a particular drug. An authorization takes precedence over therapeutic class to ICD-9 relationship editing. A pharmacy bill that currently suspends with error 738 requires manual review; prior authorization will prevent bill suspensions.

New edits have been developed to assist with the processing of pharmacy bills where a prior authorization exists. A new table has been created to capture pharmacy prior authorization decisions. The new prior authorization function will be available for use on or after December 26.

Reference: FECA Bulletins 01–01, 99–04, and 98–11.

Purpose: To notify District Offices of the new prior authorization process for prescription drugs.

Applicability: All staff.

Actions:

1. DFEC will continue to receive and process "Real-Time" bills from pharmacies for prescription drugs through intermediary clearinghouses.

2. If a "Real-Time" bill is submitted and the therapeutic class to ICD-9 relationship editing results in a suspend decision, and no authorization is found for the therapeutic class on the new table, normal relationship editing will occur resulting in a rejection. The pharmacy will receive the message, "Needs manual review". In cases where the general suspense flag is set to "Y" the pharmacy will receive the message, "All bills require manual review." When either of the previous situations occur, the pharmacy may contact the district office for authorization. The CE must enter a decision to either pay or deny the medication. The authorization will take effect

immediately at the central site. Once the decision is entered, the pharmacy can resubmit the bill right away.

3. The prior authorization function may also be used for pharmacy bills submitted through the EDI batch process or on paper. The authorization function will most commonly be used when a bill suspends with edit 738, if an EOB return is received for edit 734, or as the result of a telephone request for authorization.

4. To authorize payment for a medical condition, the CE will first double-click on the desktop application icon, and enter the Sequent user ID and password. The CE will then enter the case and NDC numbers into the authorization screen and select "Submit Query" (**see Attachment 1**). The results of the query are a complete list of existing authorizations, therapeutic class, action, add date, change date, and begin and end dates. From this screen, the CE may also view case notes, accepted conditions, NDC information, therapeutic class description and therapeutic class to IDC-9 relationships (**see Attachments 2a, see Attachments2b-c** , **see Attachment 3)**. Other pertinent information provided is the case type, status, and date of injury.

5. The CE should review the accepted condition list, which also includes modifiers, e.g., aggravation, right, left, or both. In addition, the therapeutic class descriptions and ICD-9 relationships should also be reviewed. Note that if the case contains ICD-9 accepted conditions, only the therapeutic class to ICD-9 relationships for those conditions are displayed. If the case record contains no ICD-9 accepted conditions, then all of the therapeutic class to ICD-9 relationships for that therapeutic class are shown. If necessary, the CE may consult the case file record or reference materials (such as the Physicians' Desk Reference), or seek medical guidance.

6. If the CE decides to authorize a specific medication, click the "Add/Modify" icon located in the upper right corner of the authorization screen. A message, "Add a record for this Therapeutic Class?" will appear if no record for that class exists (**see Attachment 4)**. If the user clicks on "Yes," then the add authorization screen will appear. The user must enter a decision (pay or deny) and enter the authorization period. The system decision defaults to pay, and the period defaults to today's date as the begin date, and one year from today's date as the end date. The default period of one year is considered a generous window that allows for the payment of drugs used in most cases. The user may authorize a shorter period whenever there is evidence that the medication will be used for only a limited time (i.e. antibiotics for a wound infection, muscle relaxants for a muscle sprain, etc.). Although the user can also authorize medications for periods longer than one year, this function should be used sparingly. Medications with high potential for addiction and abuse should not be approved for periods longer than one year, particularly, all opiate agonists, opiate partial agonists, and barbiturates. Once an authorization is entered, bills for medications in the same therapeutic class will pass the relationship edits until the date expires. After the CE enters a decision and authorization period, select "Save" to exit

the add option.

7. The CE may also modify any existing authorizations. The CE should enter the case number, existing NDC code and click the "Add/Modify" icon located in the upper right corner of the authorization screen (**see Attachment 5**). The system default for the modify option is what is currently defined in the record. After selecting the record for modification, the modify authorization screen will appear. The CE can modify the record to "deny" if it was originally set to "pay" and vice versa, and modify the "begin" or "end" dates. After the CE modifies the record, select "Save" to exit the modify option. If no changes are made to the record, the change date field does not change.

8. The user may enter another authorization by selecting "New Query" or may "exit" the program through the file option located on the menu bar.

9. Two new Bill 552 edits (**Attachments 6** and **Attachments 7**) have been developed for pharmacy prior authorization. Edit 335 is assigned when a therapeutic class has been denied for the date of service. Edit 336 is assigned when there is a matching authorization record (either pay or deny) for the therapeutic class, but the service dates are outside of the authorization dates.

10. An updated condensed edit list and EOB listing will be provided under separate cover.

11. Training on this Bulletin should take place as soon as possible. Offices must also be prepared to respond to telephone requests for authorization of prescription drugs.

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

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

Attachment 6 - Bill Edit 335L (Pharmacy Authorization)

December 1, 2000

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 335L

ERROR DESCRIPTION: THERAPEUTIC CLASS DENIED

EDIT DESCRIPTION: PHARMACY AUTHORIZATION TABLE CONTAINS DENIAL FOR THE THERAPEUTIC CLASS ASSOCIATED WITH NDC CODE

SUSPEND/DENY: D

OVERRIDE: N

EOB: Payment for this medication is denied.

PRIORITY: 2

BILL RESOLUTION:

This edit fails when a pharmacy authorization record has been established to deny any drug in the therapeutic class. To pay for the drug, the matching authorization record must be changed or deleted

Attachment 7 - Bill 336L (Pharmacy Authorization)

December 1, 2000

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 336L

ERROR DESCRIPTION: SERVICE DATES INVALID FOR AUTHORIZATION DATE

EDIT DESCRIPTION: PHARMACY AUTHORIZATION TABLE CONTAINS RECORD FOR THE THERAPEUTIC CLASS ASSOCIATED WITH NDC CODE; ONE OR BOTH DATES OF SERVICE ARE OUTSIDE AUTHORIZATION DATES

SUSPEND/DENY: S

OVERRIDE: N

EOB: Payment for this medication is denied.

PRIORITY: 2

BILL RESOLUTION:

1. This edit fails when a pharmacy authorization record has been established to pay or deny any drug in the therapeutic class, but one or both of the dates of service for the item being processed are outside of the specified authorization or denial range.

2. Check the service from and to dates. If keyed incorrectly, correct. If a correction is made, and the change puts the service dates wholly within the authorization or denial range, continue processing and recycle the bill.

3. If the authorization or denial dates need to be adjusted, revise the dates for the therapeutic class and recycle the bill.

4. If a previously authorized drug is not allowable for the dates of service, set to deny.

5. If a previously denied drug is still not payable, set to deny.

FECA BULLETIN NO. 01-04

Issue Date: January 4, 2001

Expiration Date: January 3, 2002

Subject: Periodic Roll Management: Evidence of Earnings

Background: Existing procedures which require a request for authorization from the claimant to obtain earnings information from the Social Security Administration (SSA) every three years have proven to be ineffective and cumbersome. Reports received from SSA rarely reflect earnings. Additionally, once evidence of earnings has been received, actions by OWCP have been inconsistent.

The frequency of the request for the SSA release form is being changed from every three years to every year, to coincide with the mailing of the CA-1032 request for earnings and dependency information from the claimant. This Bulletin also describes actions to take subsequent to the release of the form, and when evidence of earnings is received.

Reference: Federal (FECA) Procedure Manual, Chapter 2-812, paragraphs 4 – 7, 9, and 10; Title 5 U.S.C., §§ 8106 and 8110; 20 CFR 10.525 - 10.529, 20 CFR 10.535 – 10.537.

Purpose: To focus attention on this issue as a means to improving FEC performance and fiscal accountability, and to introduce new procedures aimed at more efficient monitoring and more consistent follow-up action when earnings are discovered.

Applicability: Regional Directors, District Directors, Claims Examiners, Supervisory Claims Examiners, and appropriate National Office personnel.

Action:

1. Effective immediately, the CA-935 will be mailed to claimants on the periodic roll annually, rather than every three years. The district offices will revise their current CA-1032 plan to include the mailing of a CA-935 (with enclosure SSA-581) in the package for completion and return within 30 days of the mailing. (This requirement will also affect all claimants on the daily roll for one year or more.)

2. When the duly completed and signed CA-1032 package (including the signed SSA-581 form) is returned, it will be filed in the case record. The SSA-581 form is considered valid for requesting earnings information from the Social Security Administration (SSA) for 60 days following the date it is signed by the claimant. The CA-1036 will no longer be sent routinely every three years.

3. When information of any kind is received suggesting possible employment or earnings, OWCP will issue form letter CA-1036 accompanied by the signed SSA-581 authorization form to SSA. The current SSA-581 will authorize the SSA to release any earnings information contained in its records. If the SSA-581 in file is older than 60 days, the CE must immediately request that the claimant sign a new form to be sent with the CA-1036 letter to SSA. In cases with PS (Schedule Award) status or PW (Loss of Wage-earning Capacity) status, referral to SSA

is not necessary. In such cases, a brief memo to file will be prepared, indicating that the earnings noted do not affect the claimant's entitlement to monetary compensation.

4. A second request must be made for completion and return of the CA-1032 package, including the CA-935 (with SSA-581 enclosure), if it is not received within 30 days. If the SSA-581 authorization form is not signed and returned after a second request is made, the case must be referred to the OIG for investigation.

Disposition: This Bulletin should be retained until incorporated into the Federal (FECA) Procedure Manual, or otherwise superseded.

DEBORAH B. SANFORD
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 BULLETIN NO. 01-05

Issue Date: January 29, 2001

Expiration Date: January 29, 2002

Subject: Impairment/Schedule Awards: Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment

Background: Last November, the American Medical Association once again revised its Guides to the Evaluation of Permanent Impairment. Copies of the new volume have been furnished to all district offices. Major changes found in the new version are described in the attachment.

Purpose: To provide information about the use of the fifth edition of the AMA Guides and changes found in the new version.

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

Action:

1. All Claims Examiners and Hearing Representatives should begin using the fifth edition of the AMA Guides effective February 1, 2001. As of that date, correspondence with treating physicians, consultants and second opinion specialists should reflect the use of the new edition, and form letters that refer to the AMA Guides will shortly be revised to reflect this change.

2. Awards calculated according to any previous edition should be evaluated according to the edition originally used. Any recalculations of previous awards which result from hearings, reconsideration or appeals should, however, be based on the fifth edition of the Guides effective February 1, 2001.

3. As with previous revisions to the AMA Guides, awards made prior to February 1, 2001 should not be recalculated merely because a new edition of the Guides is in use. A claimant who has received a schedule award calculated under a previous edition may later make a claim for an increased award, which should be calculated according to the fifth edition. Should the later calculation result in a percentage which is lower than the original award, the Claims Examiner or Hearing Representative should make the finding that the claimant has no more than the percentage of impairment originally awarded, and that therefore the Office has no basis for declaring an overpayment.

Disposition: Retain until the indicated expiration date.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

ATTACHMENT 05-01

AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition

The fifth edition of the AMA Guides to the Evaluation of Permanent Impairment is significantly different from previous editions. First, this edition incorporates new scientific and medical principles and diagnostic procedures. Second, it specifies when and how different measurements of impairment should be used. Last, but not least, the Guides have adopted a more user-friendly format. Chapters have been reorganized, references are provided, and each chapter contains a summary detailing the proper tables to be used in determining particular impairments.

A number of specific changes that will affect the calculation of schedule awards for FECA claimants are detailed below:

1. Whereas the fourth edition had a chapter on musculoskeletal disorders, in the new edition different chapters are assigned to the upper and lower extremities. These chapters are substantially changed from previous editions.

2. Table 16, "Upper Extremity Impairment Due to Entrapment Neuropathy", (p. 57, fourth edition) has been deleted. Upper extremity impairment secondary to carpal tunnel syndrome and other entrapment neuropathies should be calculated using Section 16.5d, Entrapment/Compression Neuropathy, and Tables 16-10, 16-11 and 16-15. The fifth edition clearly states that "in compression neuropathies, additional impairment values are not given for decreased grip strength" (p. 494).

3. The section on complex regional pain syndromes (CRPS), reflex sympathetic dystrophy (CRPS I) and causalgia (CRPS II) (pp. 495-497) has been expanded to clearly define the objective diagnostic criteria for these disorders (Table 16-16) and to detail the method for determining any associated upper extremity impairment. It should be noted that Chapter 13, The Central and Peripheral Nervous System also contains criteria that can be used to determine impairment caused by reflex sympathetic dystrophy and causalgia (Section 13.8, p. 343). However, the impairment measurements obtained from this table are expressed only in terms of the whole person, and further, the table differentiates between the dominant and non-dominant side of the body. For these reasons, the preferred method for determining impairment secondary to all complex regional pain syndromes is that described on pages 495-497.

4. The criteria for diagnosing and rating weakness not due to other ratable conditions, and for using grip and pinch strength measurements, have been clarified in Section 16.8 (pp. 507-511). The AMA Guides now state that the loss of strength should be rated separately only if it is based

on an unrelated cause or mechanism. "Otherwise, the impairment ratings based on objective anatomic findings take precedence. Decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts that prevent effective application of maximal force in the region being evaluated" (p. 508). Moreover, it continues to say that "motor weakness associated with disorders of the peripheral nervous system and various degenerative neuromuscular conditions are evaluated according to Section 16.5 and Chapter 13." Clearly, grip and/or pinch strength should not be used to calculate upper extremity impairment caused by a compression neuropathy such as carpal tunnel syndrome.

4. Regarding the lower extremities, the fifth edition Guides specifies when different evaluation methods should be used and which methods can be used in combination (Table 17-2). For example, arthritis impairments obtained from Table 17-31 cannot be combined with impairment determinations based on gait derangement (Table 17-5), muscle atrophy (Table 17-6), muscle strength (Tables 17-7 and 17-8), or range of motion (Section 17.2f). Before finalizing any physical impairment calculation that requires the combination of evaluation factors, the District Medical Advisor or Director should verify the appropriateness of the combination in Table 17-2.

5. The chapter on impairments due to pain (Chapter 18) has been greatly expanded. According to Section 18.3b, "examiners should not use this chapter to rate pain related impairment for any condition that can be adequately rated on the basis of the body and organ impairment systems given in other chapters of the Guides." This chapter is not to be used in combination with other methods to measure impairment due to sensory pain (Chapters 13, 16 and 17).

For OWCP purposes, this chapter should be applied in the following manner:

a. The physician measures organ function according to other chapters in the Guides and establishes an impairment percentage.

b. If the conventional impairment adequately encompasses the burden produced by pain, the formal impairment rating is as determined above.

c. If pain-related impairment appears to increase the burden of the individual's condition slightly, the examiner can increase the percentage found in step (a) by up to 3%.

d. If pain-related impairment appears to increase the burden of the individual's condition substantially, the examiner can increase the percentage found in step (a) by 3%.

6. A new method for the recording of range of motion (ROM) measurements is offered in the fifth edition of the Guides. This format, which is known as the SFTR method, is expected to minimize errors of transcription and to facilitate communication among examiners. Specific characteristics of this format are described in the Appendix, pages 593-598. Examining physicians may report ROM measurements in this fashion.

7. The criteria for determining impairment due to asthma have been updated. Table 5-9, "Impairment Classification for Asthma Severity", and Table 5-10, "Impairment Rating for Asthma", should be used when the pulmonary impairment in question is due to asthma. The whole person impairment thus obtained should be converted to impairment of the lungs in the usual manner. Table 5-12, "Impairment classification for Respiratory Disorders, Using pulmonary Function and Exercise Test Results," should not be used in asthma cases.

8. Respiratory impairment criteria now incorporate the lower limits of normal (according to age and gender) for the basic pulmonary function tests (Tables 5-2a through 5-7b and 5-12). This means that abnormal pulmonary function studies are defined by two criteria: (1) the measurement is lower than the predicted value, AND (2) the measurement is lower than the predicted lower limit of normal for the particular age and gender.

9. New methods are used for the calculation of visual impairment ratings. Measurements have been changed and the extra scale and losses for double vision (diplopia) and lack of a lens (aphakia) have been deleted.

FECA BULLETIN NO. 01-06

Issue Date: January 2, 2001

Expiration Date: January 1, 2002

Subject: Compensation Pay: Compensation Rate Changes Effective January 2001

Background: In December 2000, the President signed an Executive Order implementing a salary increase of 2.70 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only includes the 2.70 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, 2001.

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, 2001. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $103,623 per annum. The basis for the minimum compensation rates is the salary of $16,015 per annum (GS-2, Step 1).

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, 2001	Minimum	Maximum
Monthly	$1,000.94	$6,476.44
Weekly	230.99	1,494.56
Daily(5-day week)	46.20	298.91

The effect on 5 U.S.C. 8133(e) is to increase the minimum monthly pay on which compensation for death is computed to $1,334.58, effective January 2, 2001. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $6,476.44 per month.

Applicability: Appropriate National and District Office personnel

Reference: Memorandum For Directors of Personnel dated December 2000; and the attachment for the 2001 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 28, 2001, 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 19, 2001.

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, 2001. 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

1/02/01 46.20-69.30 230.99-346.49 46.20 230.99(923.96) 1,334.50
46.20-61.60 230.99-307.99

CA-843

1/02/01 298.91 1,494.56 (5,978.24) 6,476.44

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 all payees receiving periodic compensation payments will be generated, informing them of potential changes to their compensation benefits.

The notices will be sent as an attachment to the Benefit Statement generated after each periodic cycle. 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.

DEBORAH B. SANFORD
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. 01-07

Issue Date: January 31, 2001

Expiration Date: January 30, 2002

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 22, 2001, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobiles is increased to 34.5 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, 2001; however, if inquiry is received, appropriate adjustment should be made. Vouchers being processed for travel periods after February 1, 2001, 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.

DEBORAH B. SANFORD
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 07-01

Instruction for Submitting Travel Vouchers For reimbursement of travel and related expenses under the Federal Employees Compensation Act.

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

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**.

1. 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).

2. 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).

3. 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.

4, 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:

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 – January 21, 2001	32.5 cents per mile
January 22, 2001 – and after	34.5 cents per mile

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

5. 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.

6. ***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.

7. 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.

8. 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.

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

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

INSTRUCTION

CA-77

Revised January 2001

FECA BULLETIN NO. 01-08

Issue Date: April 23, 2001

Expiration Date: April 24, 2002

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 earn and use leave on the basis of their entire tour of duty, and who are required to work more than 106 hours per pay period. 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, the Federal Firefighters Overtime Pay Reform Act of 1998 (Public Law No. 105-277) amended Title 5 of the U.S. Code to define hours worked by firefighters in excess of 106 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 is presumed to be October 11, 1998, for the purposes of this bulletin. As Section 5 U.S.C. 8114(e) of the FECA bars inclusion of overtime pay in pay rates for compensation purposes, firefighters with pay rate effective dates on or after October 11, 1998 were not entitled to receive the "extra pay" discussed in PM 2-900.7b(21) and 8c. This change in policy was addressed in FECA Bulletin 00-05.

In December 2000, Public Law 106-554 again amended Section 5 U.S.C. 5545b(d) to include a paragraph stating that, for the purpose of computing pay under Section 5 U.S.C. 8114, the pay of a firefighter covered by Section 5 U.S.C. 5545b for hours in a regular tour of duty shall not be considered overtime pay. This amendment is deemed effective as if it had been enacted as part of the Federal Firefighters Overtime Pay Reform Act of 1998.

Reference: FECA Bulletin 89-26; FECA Bulletin 00-05; FECA Procedure Manual Chapter 2-900.7b(21) and 8c.

Purpose: To advise claims staff of the provisions of Public Law No. 106-554 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 GS-081 firefighters who are covered by Section 5 U.S.C. 5545b. These firefighters have regular tours of duty averaging at least 106 hours per biweekly pay period and generally earn and use leave on the basis of their entire tour of duty. Some firefighters work fewer hours per pay period and, because their pay rates should never have included the extra increments that are the subject of this bulletin, no adjustments are needed.

2. For firefighters with pay rate effective dates on or after October 11, 1998, "extra pay" for hours in the regular tour of duty should now be included in their pay rates. This inclusion is retroactive to October 11, 1998.

3. Under the Federal Firefighters Overtime Pay Reform Act of 1998, there are two categories of firefighters based on type of work schedule: (1) those with regular tours of duty generally consisting of 24-hour shifts and (2) those with extended tours that are built on top of a 40-hour basic workweek (usually five 8-hour shifts). Different pay computation rules apply to each category.

   a. For firefighters who generally work 24-hour shifts (which is the most common situation), use the following formula:

      (1) Annual salary / 2756 (53 hours of regular pay per week X 52 weeks) = firefighter hourly rate

      (2) Firefighter hourly rate X 106 hours = biweekly base pay

      (3) Firefighter hourly rate X 1.5 = "extra pay" rate (subject to GS-10, step 1, cap as described in paragraph 4 below)

      (4) "Extra pay" rate X (hours in regular tour in excess of 106 hours) = biweekly "extra pay"

      (5) (Biweekly base pay + biweekly "extra pay") / 2 = weekly pay rate

   Note: Most 24-hour shift firefighters have a regular biweekly tour of 144 hours (six 24-hours shifts) consisting of 106 regular hours and 38 "extra pay" hours; thus, 38 hours (144 - 106) would be used in step (4) above.

   b. For firefighters with an extended regular tour built on top of a 40-hour basic

workweek, use the following formula:

(1) (Annual salary / 2087) X 80 hours = biweekly base pay

(2) Annual salary / 2756 = firefighter hourly rate

(3) Firefighter hourly rate X 26 hours = additional biweekly base pay

(4) Firefighter hourly rate X 1.5 = "extra pay" rate (subject to GS-10, step 1, cap as described in paragraph 4 below)

(5) "Extra pay" rate X (hours in regular tour in excess of 106 hours) = biweekly "extra pay"

(6) (Biweekly base pay + additional biweekly base pay + biweekly "extra pay") / 2 = weekly pay rate

Note: A common schedule would be a 40+16 weekly tour, which translates into a biweekly tour of 112 hours, including 6 "extra pay" hours to be used in step 5 above.

4. The Federal Firefighters Overtime Pay Reform Act of 1998 provides overtime ("extra pay") for hours in the regular tour of duty to both FLSA nonexempt and exempt firefighters. The weekly pay rates are computed in the same manner for both types of firefighters *except* there is a cap on the "extra pay" hourly rates for FLSA exempt firefighters. The cap is set at 1.5 times the GS 10, step 1 hourly rate (computed using the 2087 divisor) but the capped rate may not fall below the individual firefighter's hourly rate of basic pay.

5. When making loss of wage-earning capacity determinations for firefighters with pay rate effective dates prior to October 11, 1998, 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 GS-081) 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
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 BULLETIN NO. 01-09

Issue Date: February 5, 2001

Expiration Date: February 5, 2002

Subject: COP Nurse Intervention

Background: Amended FECA Bulletin 00-15, issued September 18, 2000, incorporated changes to the Continuation of Pay/Return to Work (COP/RTW) initiative. These changes enabled district offices to identify cases in need of prompt adjudication, and assisted Claims Examiners (CE) in prioritizing their adjudication efforts. The changes included the addition of four triage codes to be used in cases with no full-time return to work: "1" - no return to work due to surgery, invasive diagnostic testing, physical therapy, 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. The Bulletin also discussed changes planned for the automated system that would fully utilize the triage codes and facilitate prompt Quality Case Management (QCM) action on triaged cases. Those automated changes have now been implemented.

Purpose: To describe the automated changes and provide guidelines for Claims Examiner/Telephonic Case Manager (TCM) actions relevant to COP/RTW case management.

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

Action:

COP/TCM Nurse Responsibilities

1. The web-based "home page" has been updated to include a "TRIAGE CODE" section. (See Attachment 1 - Sample COP/RTW Case Update screen.) The COP/TCM should "click" on the appropriate triage code description once he or she has determined that the claimant: 1) is not working due to surgery, diagnostic testing or physical therapy; 2) is not working for other reasons; 3) has returned to work part-time; or 4) is not cooperating with nurse intervention. Triage code "4" should only be entered if a claimant specifically expresses unwillingness to cooperate and the COP/TCM is unable to obtain return to work information from the employer.

2. If no triage code is indicated at the end of the COP/TCM's 30-day time limit, the system will automatically choose a triage code upon locking access to the home page. When no return to work is indicated, the system will choose triage code "2". When "RETURNED TO WORK TYPE" is "unknown" or "part time", the system will chose triage code "3".

3. The format of the case closure worksheet has been revised. (See Attachment 2 - Sample COP/RTW Case Worksheet.) This updated version should be used for all cases.

Claims Examiner Responsibilities

1. When the CE enters part-time return to work data in the COP/RTW Case Update screen (Case Management Screen 41), the system will record a triage code "3" and lock out access to the web-based home page.

2. Short-form closure cases with triage code "3" in which the claimant has been off work for 45 or fewer days will flip open for adjudication with an expired call-up noting, "CLOSED CASE REOPENED-COP/TCM CASE WITHOUT FULL-TIME RTW". Short-form closure cases with triage code "2" in which the claimant has been off work for 35 or more days will flip open for adjudication with an expired call-up noting, "CLOSED CASE REOPENED-CLAIMANT STOPPED WORK OVER FIVE WEEKS AGO". Short-form closure cases with triage codes "1" and "4" will "flip" open for adjudication with an expired call-up noting, "CLOSED CASE REOPENED-CLAIMANT NOT WORKING-TRIAGE PRIORITY". The CE should prioritize adjudication of these cases in the order of the triage codes (i.e. triage code "1" is the top priority, triage code "2" is the next priority, etc.).

3. Acceptance of a case with a triage code will trigger a prompt stating, "ACCEPTED CASE WITH NO RTW OR RTW PART-TIME - INITIATE QCM". The CE should immediately initiate field nurse referral. Manual creation of a QCM record is no longer required. Both acceptance of a triaged case and entry of a triage code on an accepted case will automatically create a QCM record with a new QCM category "T". The QCM TRACK DATE will be set to the

DATE STOPPED WORK and a new status code "TCC - Triage COP Case" will automatically be entered. For those cases with triage code "3", work status code "PLP - pre-QCM RTW LD PT" will also be automatically entered using the date of return to work. Category "T" cases will not be included in District Office Lost Production Days (LPD) counts.

4. Entry of TPCUP decision codes A1/A2 and I1/I2 will automatically adjust the QCM TRACK DATE, eliminating the need for CE's to manually adjust the QCM records. In cases with no work status code, the TRACK DATE will be changed to the first date claimed on the paid Form CA-7 (date wage loss began). In cases with work status code "PLP", the TRACK DATE will be changed to the decision date on the first paid Form CA-7. The QCM category will also be changed to "A" or "B" as appropriate.

5. In category "T" cases where the claimant returns to full-time work during the COP period, the CE will enter a new work status code, "TRC - Triage Case with RTW during COP Period". The system will automatically "zero out" the QCM record in cases with the "TRC" code, so manual adjustment of the QCM category is no longer required.

Systems Manager

1. Three existing Online Query System 2 (OQS2) reportsC"Traumatic Injury Cases UN/UD", "Traumatic Injury Cases UN/UD and Controverted", and "LT/NLT Closures Now Reopened"Cwill be revised to include triage codes. The "Adjudication Triage Report" (CASE649) is supplanted by these revised reports and will be removed.

2. The "No Intervention Report" (CASE633) will be revised to include triage codes.

3. A new OQS2 report of "COP QCM Cases with no Action" will be available to identify QCM category "T" records where staff nurse referral has not occurred. The "QCM Referral Triage Report" (CASE650) is supplanted by this new report and will be removed.

4. The weekly "COP-QCM Cases Report" (CASE651) is no longer necessary as a result of the automated changes and will be removed.

Disposition: Retain until the expiration date or until superseded.

DEBORAH B. SANFORD
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 BULLETIN NO. 01-10

Issue Date: April 30, 2001

Expiration Date: April 29, 2002

Subject: Bill Pay/BPS – Sampling of Bills

Background: The supervisory sampling of bills was initiated in 1994 (FECA Bulletin 94-10), with t enhancement to the Medical Bill Processing System. The procedure was reissued and updated in 199 (FECA Bulletin 98-05) because of reports from the Office of the Inspector General citing numerous errors in bill processing and the finding in several accountability reviews that bill sampling was not being conducted in a number of district offices.

Results of the medical quality index introduced during the 2000 accountability reviews suggest that processing errors have decreased in number and indicate that bill sampling is routinely conducted in t district offices.

However, during the same period, multiple changes have occurred within the FECA program that impact on the bill sampling procedures. Implementation of the Correct Coding Initiative (CCI) increased the complexity of the automated editing and bill resolution decisions, as well as the need fo accurate keying. Medical coding specialists have joined the staff in the district offices to resolve bills suspended for complex issues, to serve as medical provider liaisons, and to conduct quality assurance activities. Imaging of case information and medical bills in the district offices has altered some of the bill resolution manual processes.

This bulletin reviews and updates the bill sampling procedures to improve the probability of detecting significant errors and trends in bill processing, and to take into account the changes mentioned above

Purpose: To transmit updated procedures for the sampling of bills.

Reference: FECA Bulletins 94-10 and 98-05.

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

Action:

1. The Medical Coding Specialist (MCS) will sample bills processed through the BPS on a mont basis. The MCS will examine all the bills in the sample in accordance with the instructions in Attachment 1 and complete the Bill Sampling Worksheet.

2. By the tenth day of each quarter, the MCS will provide a report of the previous quarter's findi to the District Director. The report should include (a) the worksheet with the total number and perce of bills with errors and subtotals for each type of error, and (b) recommended corrective action(s).

3. A copy of the quarterly report (findings and corrective actions) will be provided to a designate National Office Medical Coding Specialist, no later than the 20th day of the quarter, along with a tim table for corrective actions. The National Office Medical Coding Specialist will compile a national level report for management staff.

4. Each sample will be selected on an automated basis by the Monthly Bill Sampling OQS2 repo and by retrieving DO information from a shared drive. The DO systems manager will import the cas information into a sampling worksheet and route it to the MCS. The sample will comprise 32 line ite that failed one or more of the following edits according to records in the b22 table: 301, 364, 371, 37 375, 377, 708, 716, 738, 746, 758 and 766. Bills with bypass codes and bills paid using the AUTHO code will also be included. The sample should be composed of 69% edits, 25% bypass codes and 6% AUTHO codes. A back-up list will also be given to the MCS.

5. Separate batch sampling, as described in FECA Bulletin 98-05 is discontinued.

6. The Accountability Review and Management Review processes will verify that bill sampling conducted in accordance with the above instructions and that corrective actions are implemented on timely basis.

Disposition: This Bulletin should be retained until incorporated into the Federal (FECA) Procedure Manual, or otherwise superseded.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

Distribution: List No. 4--Folioviews Groups B and D
(All Supervisors, Fiscal Officers,

Fiscal and Bill Pay Personnel,
Systems Managers, and Technical
Assistants)

Attachment 10-01

BILL SAMPLING INSTRUCTIONS:

1. For each bill in the sample, the MCS should obtain a Central history and an on-line history. The Central history contains receive date, payee address, authorizing initials and ineligible amounts and codes. The on-line history contains service dates, units, procedure codes, bypass codes, charge amou and paid amounts, as well as data on denied bills and bills that reject in the Central processing. The BP040 reports will also be needed to obtain the payment address. Any information not available on these reports should be obtained through the Sequent database or by reviewing the physical case file.

2. The MCS receives the monthly bill sampling worksheet that includes all data elements: case file number, batch ID number, bill ID number, line item number, dates of service, failed edit, procedure c NDC code as applicable, and billed amount.

3. The MCS reviews the keying/initial processing of each bill in the sample by reviewing the following data elements and comparing the data in the automated history with the data as found on th bill:

a. Receive date
b. Date(s) of Service (DOS)
c. Procedure code
d. Modifier(s)
e. Units
f. If the bill was paid, is the address on the bill the same as the address paid?
g. If the bill was paid, was the correct provider selected (correct sequence number)?

The MCS introduces a check mark for every keying error found into the appropriate column in the Worksheet.

4. The MCS reviews the authorized amount initials. If the bill exceeded the maximum for the provider type, are the authorizing initials present on the bill? Are they in agreement with those in the system? Any error found in this process such as bills that exceed the DO provider maximum but that not show authorizing initials, etc. is marked on the Worksheet.

Note: To complete this task, the MCS must have a list of the provider maxima in the local system.

5. The MCS reviews the amount charged. Are there any of the charge amounts on the bill different from the amounts on the history? If so, were changes made to the bill, and are the changes justified? Ineligible amount codes and amounts should be considered in this respect.

6. The MCS reviews the bills paid with the use of bypass codes. Was the bypass code correctly applied? If not, should another code have been used or was a bypass code necessary at all? Should t bill have been denied? Any misuse of a bypass code counts as an error.

7. The MCS reviews the use of the AUTHO code. This code is used only when necessary and wher no existing CPT code is available and the bill, case file, or case notes show prior authorization of the procedure. When no such authorization exists or when there is no compelling reason for the use of th code, the MCS assigns an error in this category.

8. The MCS reviews adjudication decisions. When bills suspend for relationship edits, was the corre decision made with respect to the relationship of the service to the accepted condition(s)? Was an authorization given? Were the CCI edit suspensions properly resolved? Errors are assigned as warranted.

9. When the review is completed, the MCS totals the number and types of errors on the Worksheet, a analyzes results. The MCS communicates his/her findings and recommended corrective actions to supervisory personnel.

10. At the end of every quarter, the MCS prepares a formal report containing all the Worksheets, a narrative summary of findings, any recommended corrective actions with a suggested timetable, and list of corrective actions from previous period that were completed during the quarter. He/she forwar this document to the appropriate supervisory personnel by the 10th day of the following quarter.

FECA BULLETIN NO. 01-11

Issue Date: June 4, 2001

Expiration Date: June 4, 2002

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

Background: On November 5, 1999, FECA Bulletin 00-01 was issued. That bulletin outlined the roles of all parties using PDS in the medical scheduling process. At the same time, the PDS was updated to include additional physicians, be more user-friendly, and allow management tracking of scheduling to assure adherence to the rotational system.

Recently, a new version of PDS (PDS32) has been piloted in the Seattle district office. This version will shortly be deployed in all district offices. The changes made in this version will be immediately visible to users, as the system is now Windows-based, allowing for use of the mouse as well as keyboard commands. The operation of the system, however, is substantially

similar to the previous version, with some enhancements. The enhancements include the ability to both print an appointment report as the appointment is scheduled and produce a more detailed list of physicians when one is needed outside of the claimant's zip code (the list now includes those outside the next numerical zip code along with their city and state so that medical schedulers may use their knowledge of the region to schedule the closest possible appointment). Use of a physician outside of the claimant's home zip code will produce a mandatory note entry field so that the use of another zip code can be explained.

Reference: FECA Bulletin 01-11; PDS User Guide

Purpose: To familiarize district office personnel with the update of the PDS and provide job aids for users.

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:

All PDS users should familiarize themselves with the new PDS upon deployment in each district office. A job aid to assist medical schedulers in navigation of the system has been provided as Attachment 1 to this Bulletin. This is meant to supercede the PDS User Guide section for Schedulers.

Additionally, users are reminded that when a mandatory note field pops up, the note entered must fully explain the reason for either the use of a different zip code or the reason for the bypass (i.e. the entry of the word "other" in the note field required by an "O" bypass is not sufficient).

A job aid for managers has been created, and is Attachment 2. This will be incorporated into the PDS User Guide as well.

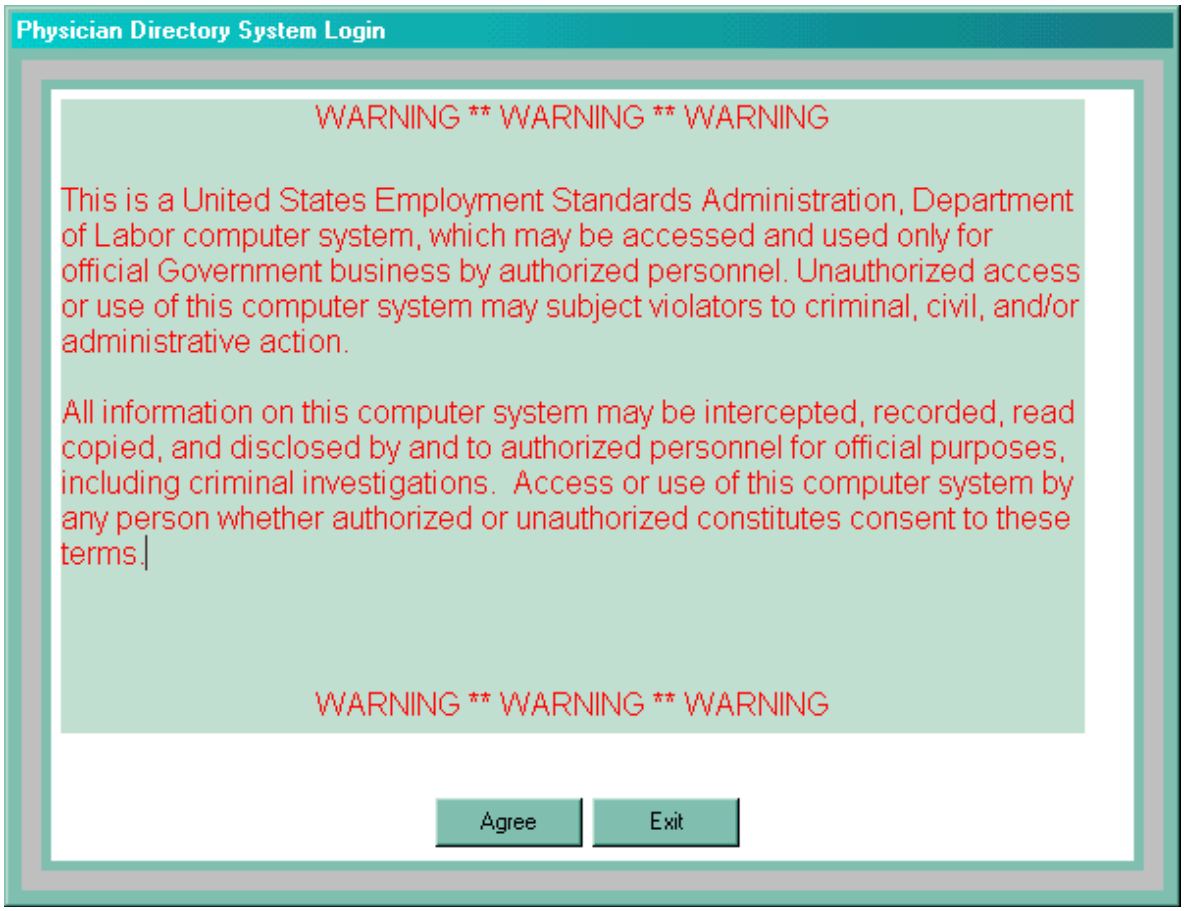
Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual.

DEBORAH B. SANFORD

Director forFederal 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)

Scheduling appointments:

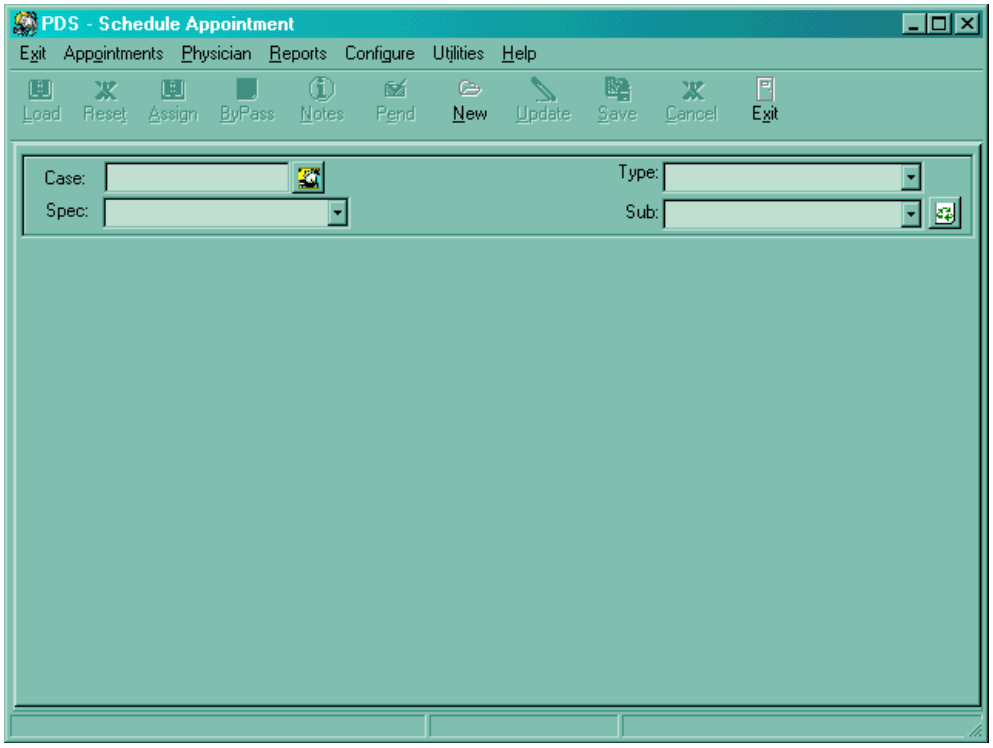
Logging in:



You will be greeted with the following login screen:

You must enter or click on "Agree" to continue. Then, you will have to log on, using the same login ID as with the previous version of PDS. Once you have logged on, you'll get the following screen:

To schedule an appointment:



After logging in, the Cursor should already be positioned in the **Case Number** field. In the **Case Number** field type a case number. If you don't have the case number, you can choose to search using other criteria such as Claimant last name (more on this below). Then press the 'Tab' key (or click with the mouse) to move to the **Appointment Type** Field.

In the **Appointment Type** field select an appointment type by either pressing the 1st character of the available appointment types

I = IME
2 = Secop
A = Award

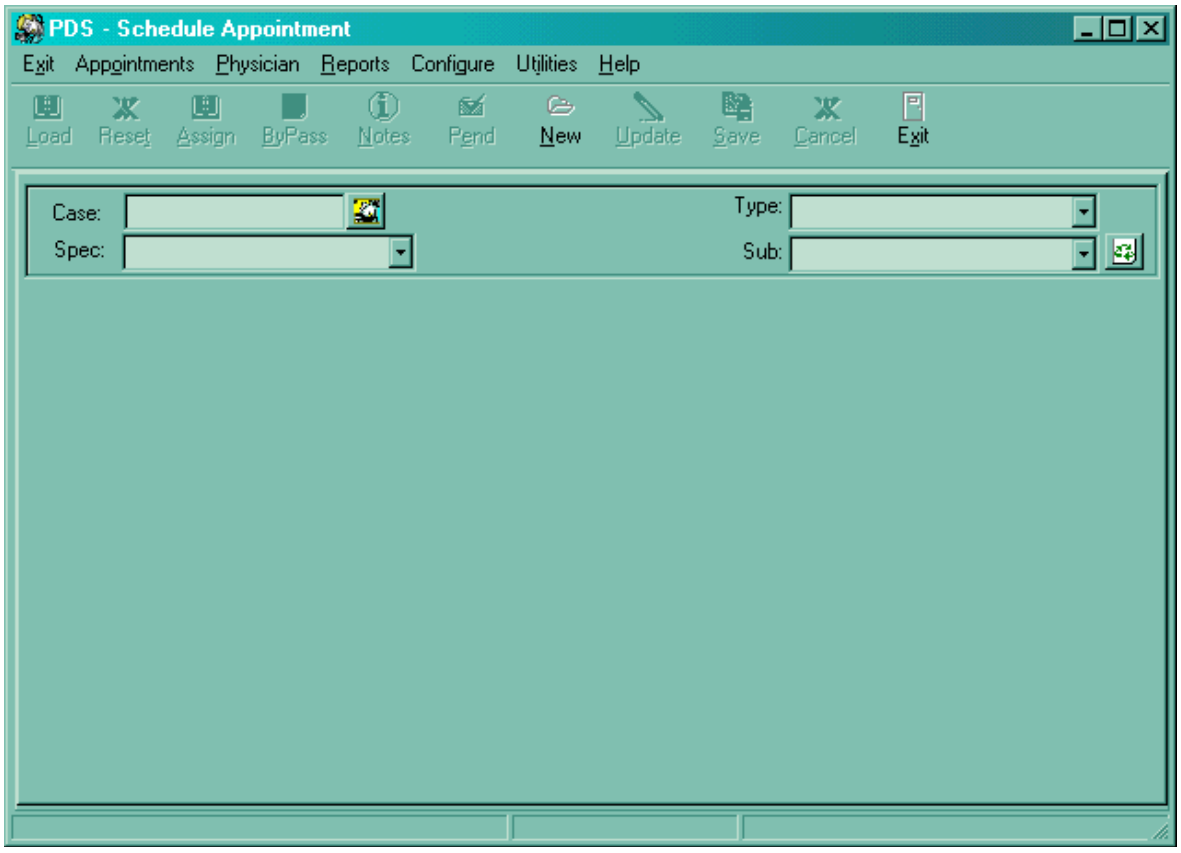
or by selecting the appointment type from the drop-down combo box. Then press the 'Tab' key (or click with the mouse) to move to the **Specialty** Field.

In the **Specialty** field select a specialty by entering the first letter of the specialty that you are looking for or use the mouse to view the drop-down list. Once this is done, click "Load" to select the next available doctor.

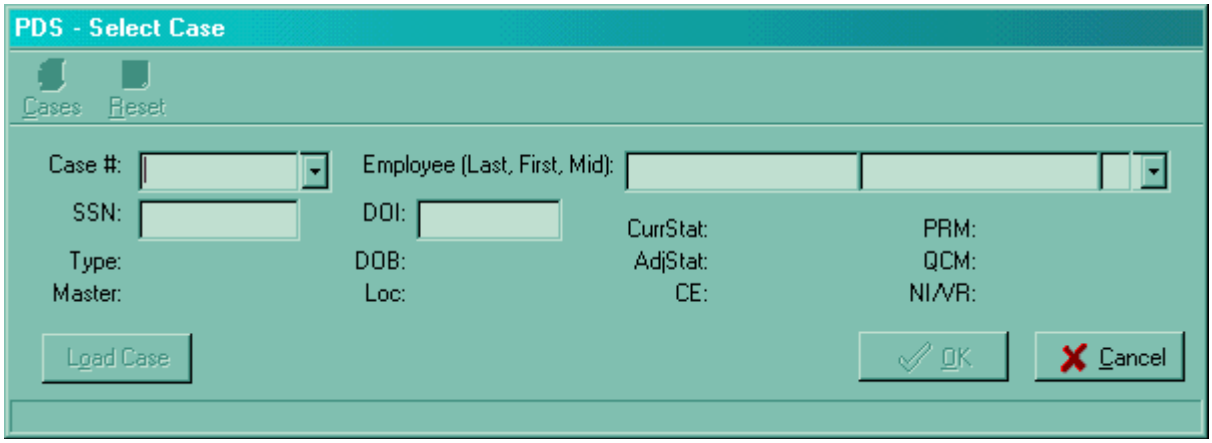
Once you have selected a doctor, you can assign the case to that doctor by either pressing the ALT + A keys simultaneously or clicking on "Assign." This will bring up the **Schedule Doctor** screen.

After you have set the appointment, you can document the appointment date on the **Schedule Doctor** screen by using the arrow keys on the keyboard or by clicking the arrows on that box. You can then tab to the appointment times box and set the time of the appointment the same way. You can then click "OK" to confirm scheduling. You will get confirmation that the appointment was scheduled for this doctor. You can then select "Print" and a record of the appointment will be printed for the file. Then, click the "Close" button to return to the main screen if you need to schedule another appointment.

Searching by claimant name:



Press this button to get the **Select Case** screen:



Enter the claimant's name into the **last name** field. A list of all cases with that last name will come up and you can scroll to find the correct one. When you locate it, you can select it by double-clicking it, or arrowing down to it and entering. Once the case selection record pops up, if the case selected is correct, click "OK" to schedule an appointment.

Bypassing a selected physician:

If the physician selected by PDS cannot be used, he or she should be bypassed, just as in previous versions of PDS. The reasons for bypass have not changed, and if there is question as to the validity of a bypass, FECA Bulletin 00-01 should be consulted.

After determining that a bypass is necessary and valid, press ALT + B keys simultaneously or click "Bypass." This will bring up the **Bypass Doctor** screen.

Find your reason for bypassing in the **Select Bypass Reason** box. If the bypass is any reason besides "Other," click "OK." If you have selected "Other," you must enter a note. Once you have clicked "OK," you will go back to the main form where the next available physician that meets the selection criteria will be displayed. You can then continue to schedule the appointment with the next available physician.

If you can't complete scheduling:

You can "pend" an appointment until you can finalize the scheduling by pressing "ALT + P" or clicking the "Pend" button. Click "OK" to confirm. If you later want to finalize this appointment, you can do so by selecting "Pending Appointments" on the "Appointments" menu.

Entering physician notes:

You can enter notes at any time during scheduling once you have selected the physician by either clicking "Notes" or by keying ALT + N. Once you have typed your note, either click "OK" or

type ALT + O; this will confirm that your note has been saved and take you back to where you were.

Exiting the system:

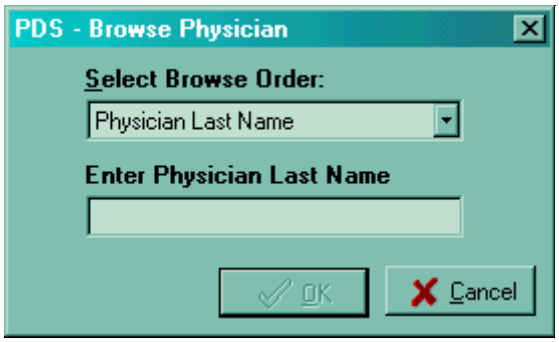
You can exit PDS32 by either clicking on the "X" (as in other Windows programs) or clicking on "Exit" (the door symbol).

Updating/Adding Physicians:

Under the "Physician" menu, you can either update a physician's record or add a new physician.

To update a physician's record:

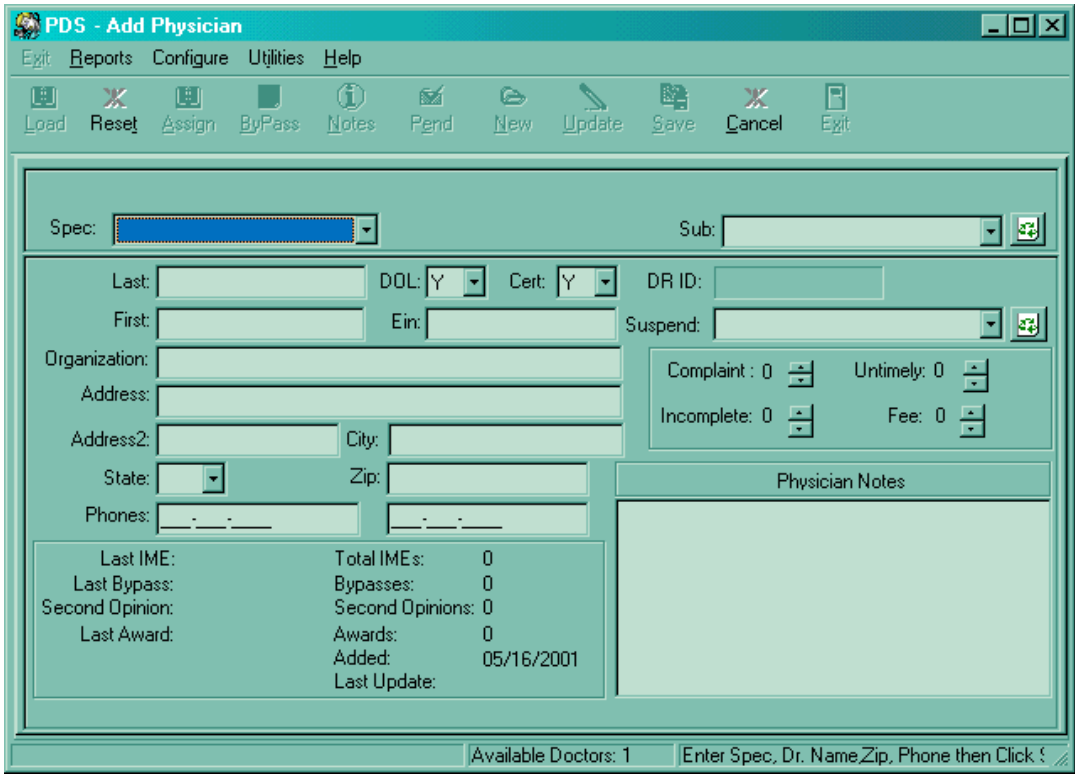
Choose "**Update Physician**" from the "Physician" menu. This will bring up the following dialog box:



Then, to update a specific physician, enter that physician's last name (you can also browse by zip or specialty). You will get a listing of all physicians meeting that criteria. Select the physician you wish to update and either enter or double-click. This will bring up the **Update Physician** screen. You are then free to change any information on that physician's record.

To add a new physician:

Choose "**Add Physician**" from the "Physician" menu. This will bring up the following dialog box:



Once you have entered all information, either click on "Save" button or press the ALT + S keys simultaneously to save the information.

Updating/Adding Users:

Managers can add and update PDS users. Every PDS user MUST have an entry in this screen before logging in to PDS. Otherwise, PDS will not allow the user to log on. The User_ID must match the users Unix login ID.

To add a new user:

In the **Utilities** menu, click "Add/Edit Users." This will bring up a table of all users currently permitted PDS access. To add a new user, either select an empty row or create a new row in the grid by pressing the Insert key on the keyboard. Enter information in each field then use either the Arrow key or Tab key (or the mouse) to move to the next field. To save the new user information, select a different row in the grid and the user information will be automatically saved. Pressing the Esc key prior to moving to a different record cancels the New User record.

To Update an existing user:

In the table, select an existing user by using either the arrow keys or the mouse. Type over the existing information in the necessary field(s) then select a different record to automatically save the updated information. If a mistake is made while updating a user then the information can be changed again by typing over.

To **Delete a User**:

Select the user with either the mouse or the arrow keys. Press and hold CTRL + DELETE keys to display the Delete record confirmation dialog:

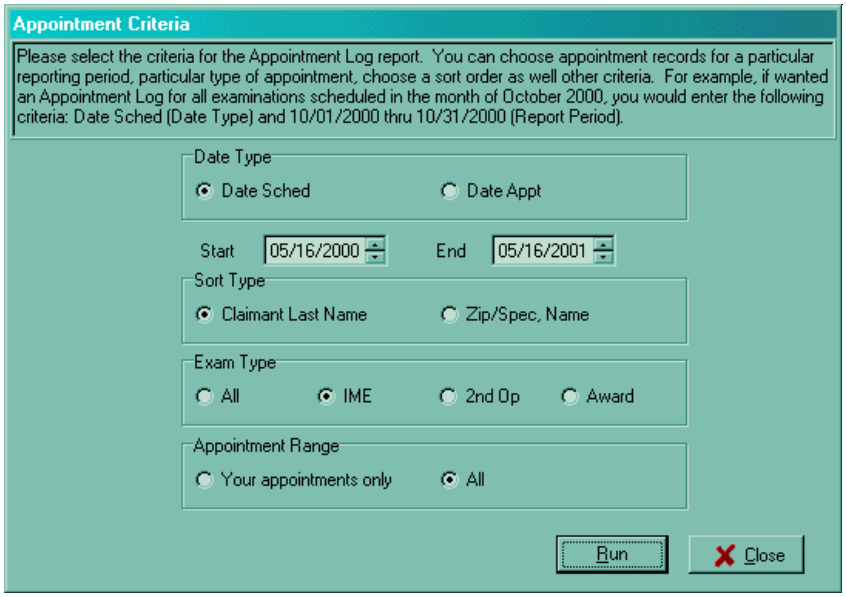
Click "OK" to remove the user from PDS.

Reports:

The reports available are the same as those in the prior PDS version. You can access any report by clicking on the "Reports" header and selecting from the pull-down menu. The types of reports are outlined below:

Appointment Log:

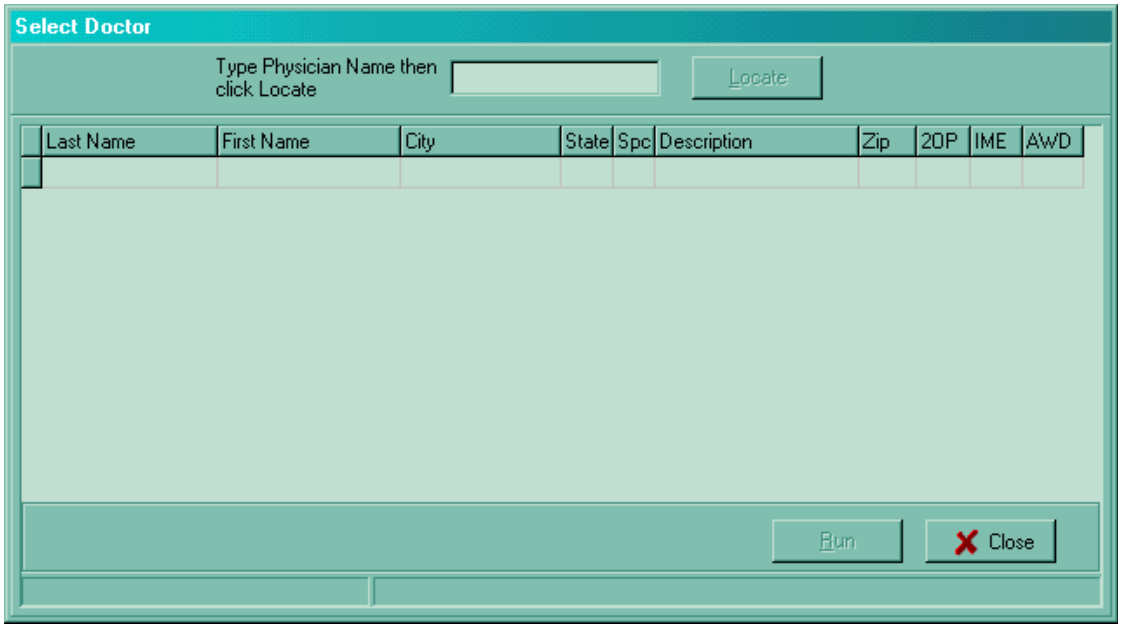
Selecting this option brings up the following screen:



You can select the report criteria you want, then click "Run." You will then get a window showing a preview of the report that will print. You can then either cancel or run the report.

Physician History:

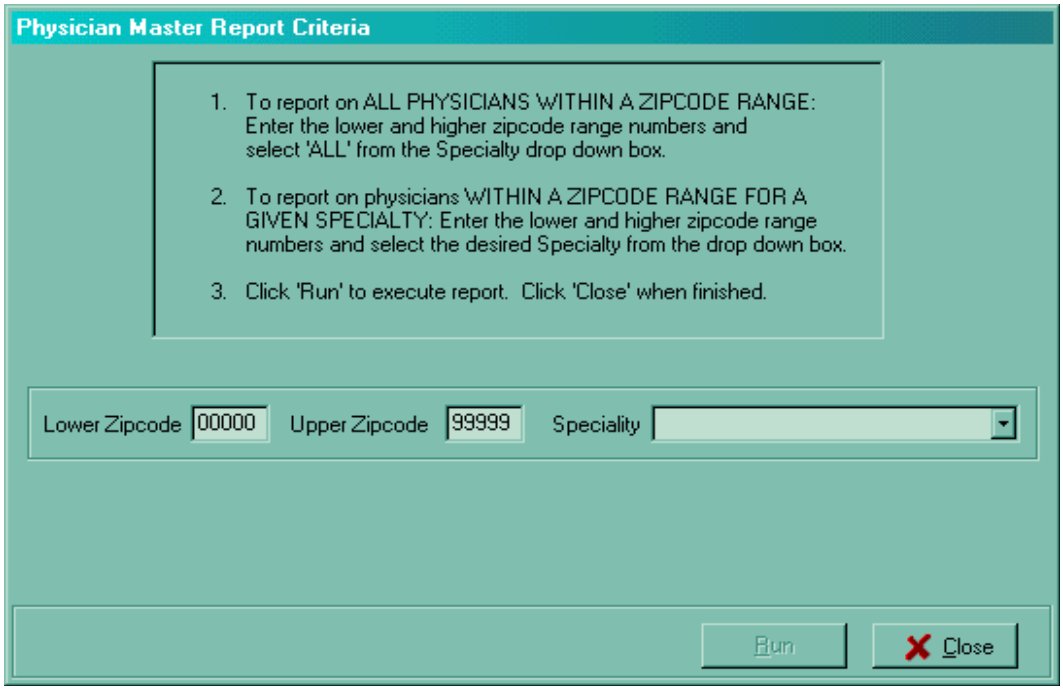
To get a history of all appointments scheduled for a specific physician, select this option. The following screen will come up:



Enter the name of the physician whose history you want to view. Then, click "Locate." The physician’s history will be displayed.

Physician Master:

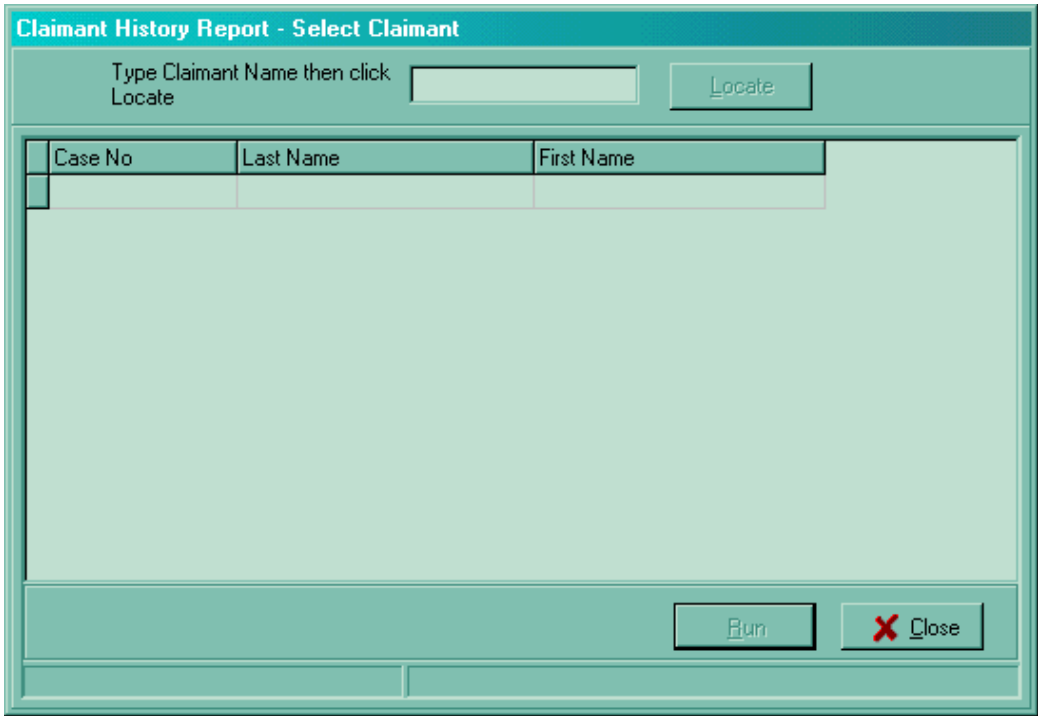
This option allows you to get a list of all physicians within a zip code, and you may sort further by specialty. When you select this item, you get the following screen:



Once you enter the specifics for the report, you will get a print preview of the report, and you can either cancel or run the report.

Claimant History:

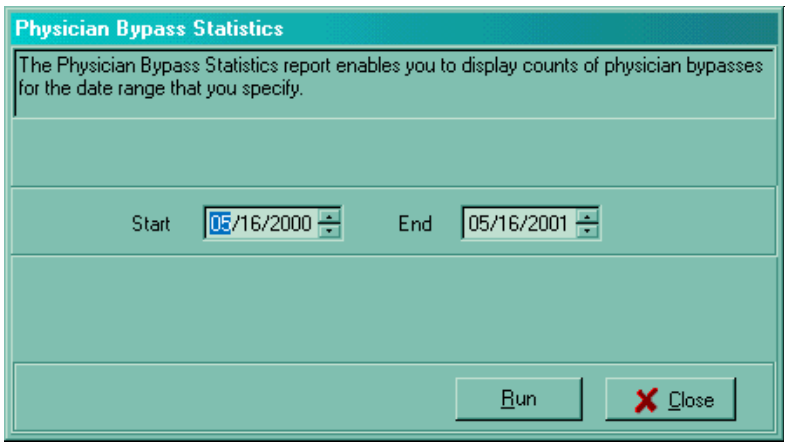
This allows you to obtain a record for all appointments scheduled through PDS for any claimant. Selecting this option brings up the following screen:



When you enter a last name, a listing of all claimants with that name who have had PDS appointments scheduled comes up. You can click on the desired claimant and then you will get a report to print out listing the details of all appointments scheduled.

Bypass Statistics:

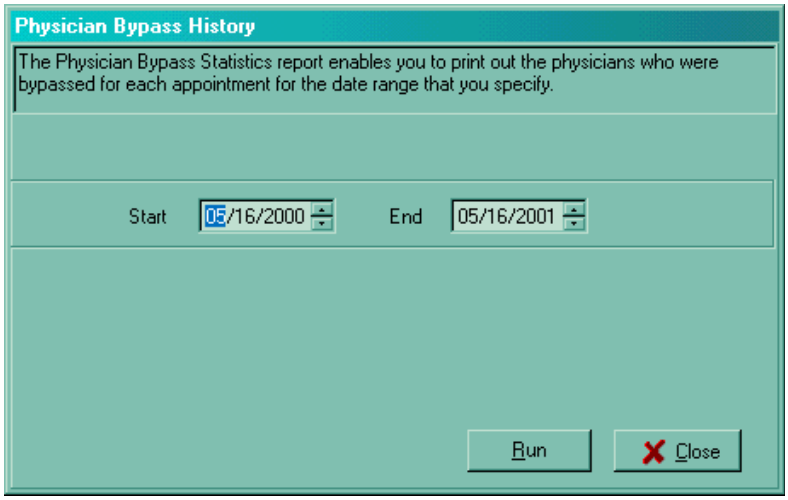
This allows you to get a composite statistic of your office's use of bypass codes for any period. Selecting this item will bring up the following:


Physician Bypass Statistics
The Physician Bypass Statistics report enables you to display counts of physician bypasses for the date range that you specify.
Start
05/16/2000
End
05/16/2001
Run
Close

You can then specify the period for which you'd like to see bypass statistics and select "Run." When this is selected, you will get a preview of the report that will print and you can either cancel or run it.

Bypass History:

This will allow you to run a complete history of all appointments scheduled for a given period and list the bypasses logged in scheduling those appointments. Selecting this option gives you the following screen:

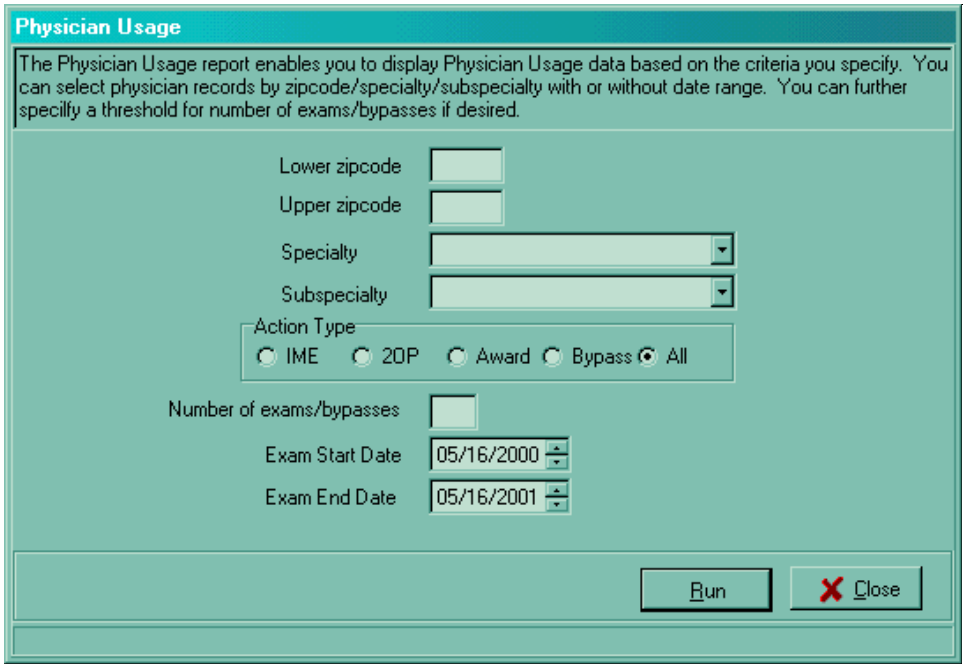


Once you enter the dates you wish to see and click "Run," you will again be given a print preview and be able to either run the report or cancel.

Physician Usage:

This allows you to display Physician Usage data based on the criteria you specify. You can select physician records by zip code/specialty/subspecialty with or without date range. You can further specify a threshold for number of exams/bypasses if desired.

When you select this, you get the following screen:



Once you enter the criteria for your usage search, you will get a print preview of the data, and you can either run it or just view it and cancel.

FECA CIRCULARS (FC)--INDEX

	and Veterans Affairs, and the Federal Judiciary and the U.S. Postal Service, Case Management Users' Manual, Appendix 4-7
FC 01-04	**Selected ECAB Decisions for April – June 2000**
	Loss of Wage-Earning Capacity - Darryl Leggett, Docket No. 98-1531, issued April 4, 2000
	Determining Pay Rate - Walter L. Neitzel, Docket No. 98-1442, issued April 26, 2000
	Pay Rate for Compensation Purposes - Learner's Capacity - Carolyn M. Bosley, Docket No. 99-28, issued April 20, 2000
	Schedule Award - Including Pre-Existing Impairment to Vision - Mike Reid, Docket No. 98-2593, issued June 9, 2000
	Performance of Duty - Impact of State Decision Regarding Termination Lynda Moore, Docket No. 99-771, issued June 22, 2000
	Affirmative Defense - Use in Rescinding Acceptance Patricia McKibben (widow of Jimmy McKibben), Docket No. 00-452, issued June 9, 2000
	Penalty Provision S 8106(C) - Refusal of Suitable Work Ruggiero A. Pignoti, Docket no. 99-190, issued May 15, 2000
FC 01-05	**Selected ECAB Decisions for July - September, 2000**
	APPEALS - TIMELY FILING - Curtis A. Hobbs, Docket No. 1997-1776, Issued August 24, 2000
	RECONSIDERATION - NON-MERIT REVIEW Granville O. Allen Docket No. 1998-0735, Issued August 4, 2000
	REFUSAL OF SUITABLE EMPLOYMENT - Veronica L. Fiorentino, Docket No. 1999-1252, Issued August 3, 2000
	SCHEDULE AWARD - HEARING LOSS - Jeffrey J. Stickney, Docket No. 1999-1659, Issued August 7, 2000
	SCHEDULE AWARD - MAXIMUM MEDICAL IMPROVEMENT/AUGMENTED COMPENSATION RATE Mark P. Brown, Docket No. 1999-0585, Issued August 2, 2000
	WAGE EARNING CAPACITY - CONSTRUCTED POSITION - Beverly A. Berry, Docket No. 1999-1691, Issued August 11, 2000
FC 01-06	Current Interest Rates for Pronpt Payment Bills and Debt Collection Promt Payment Inter est Rates (attachment)

FECA CIRCULARS (FC)--TEXT

FECA CIRCULAR NO. 01-01 **January 9, 2001**

SUBJECT: DUAL BENEFITS – FERS COLA

Effective December 1, 2000, Social Security Benefits will increase by 3.5%. 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 revised ACPS Program. The adjustment will be made effective with the periodic roll cycle beginning December 4, 2000. No adjustment will be made for the period December 1, 2000 through December 3, 2000.

If there are any cases currently being adjusted for FERS Dual Benefits that have not been entered correctly, please ensure that all necessary corrections have been made.

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, 2000: 3.5%
- 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%

DEBORAH B. SANFORD
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. 01-02 **January 9, 2001**

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

The interest rate to be assessed for the prompt payment bills is 6.375 percent for the period January 1, 2001 through June 30, 2001.

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 also changed. The interest rate for assessing interest charges on debts due the Government is 6.0 percent for the period of January 1, 2001 through December 31, 2001.

Attached to this Circular is an updated listing of both the Prompt Pay and 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)

FECA CIRCULAR NO. 01-03 **March 30, 2001**

SUBJECT: Code changes for the Departments of Agriculture, Defense, Justice, Labor, State, and Veterans Affairs, and the Federal Judiciary and the U.S. Postal Service, 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 Agriculture, two new codes have been added to reflect Farm Service Agency County Offices and employment by certain colleges in the Cooperative Extension Service. For the Department of Defense, three agencies have been renamed, including one agency which was formerly part of the Defense Logistics Agency but is now an independent Defense agency. For the Department of Justice, chargeback code 1542 has been added to reflect the creation of the National Drug Intelligence Center. For the Department of Labor, four new chargeback codes have been added, and three existing agencies have been re-named, all within the Department of Labor's Employment and Training Administration. For the Department of State, three agencies have different names, and four new chargeback codes have been added to reflect injuries reported by separate Bureaus in the Department of State. For the Department of Veterans Affairs, two current chargeback codes have been changed to reflect the move or expansion of a VA Medical Center. For the Federal Judiciary, the name of the U.S. Claims Court has been changed to reflect the new title of the Court of Federal Claims, and a new chargeback code has been added to reflect coverage for employees of the Court Services and Offender Supervision Agency, part of the District of Columbia Court system covered under FECA. Finally, for the U.S. Postal Service, 11 new chargeback codes have been added to reflect injuries reported by employees of 10 separate Area Offices and 1 Remote Encoding Center.

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.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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.

Trans-action type	Code	Dept.	Agency
Add	8508	Agric	Farm Service Agency County Offices
" "	8510	" "	Cooperative Extension Service - 1890 Colleges
Add	1542	Justice	National Drug Intelligence Center
Add	1102	Labor	ETA - Office of the Assistant Secretary

" "	1132	" "	ETA - Office of Financial & Administrative Mgmt
" "	1133	" "	ETA - Office of Technology & Information Services
" "	1134	" "	ETA - Office of Adult Services
Add	1337	State	Nonproliferation Bureau
" "	1338	" "	Office of the Chief of Protocol
" "	1339	" "	Bureau of Western Hemisphere Affairs
" "	1340	" "	Bureau of South Asian Affairs
Add	1372	Judiciary	Court Services & Offender Supervision Agency
Add	5106	USPS	Allegheny Area Office, Cleveland, OH
" "	5107	" "	Capitol Metro Area Office, Gaithersburg, MD
" "	5108	" "	Great Lakes Area Office. Bloomingdale, IL
" "	5110	" "	Midwest Area Office, Kansas City, MO
" "	5111	" "	New York Area Office, New York, NY
" "	5112	" "	West-Denver Area Office, Denver, CO
" "	5113	" "	Pacific Area Office, San Francisco, CA
" "	5114	" "	Southeast Area Office, Jacksonville, FL
" "	5115	" "	Southwest Area Office, Dallas, TX
" "	5117	" "	West-Seattle Area Office, Seattle, WA
" "	5120	" "	Glendale, AZ Remote Encoding Center (REC)
Change	3012	Defense	from: NIMA North Annex to: NIMA Geographically Separate Units
" "	3069	" "	from: Defense Systems Management College to: Defense Acquisition University
" "	3037	" "	from: Defense Contract Mgmt Cmmd, West District to: Defense Contract Mgmt Agency, West District
" "	3073	" "	from: Defense Contract Mgmt Cmmd, Northeast Dist to: Defense Contract Mgmt Agency, Northeast Dist
" "	3074	" "	from: Defense Contract Mgmt Cmmd, Mid-Atl Dist to: Defense Contract Mgmt Agency, Mid-Atl Dist
" "	3075	" "	from: Defense Contract Mgmt Cmmd, N Central Dist to: Defense Contract Mgmt Agency, N Central Dist

Trans-action type	Code	Dept.	Agency
Change	3076	Defense	from: Defense Contract Mgmt Cmmd, South Dist to: Defense Contract Mgmt Agency, South Dist
" "	3077	" "	from: Defense Contract Mgmt Command, All Other to: Defense Contract Mgmt Agency, All Other
Change	1103	Labor	from: Bureau of Apprenticeship & Training to: Ofc of Apprenticeship Trng, Empl & Labor Svcs
" "	1115	" "	from: Ofc of Strategic Planning and Policy Devel to: Office of Policy Research
" "	1125	" "	from: U. S. Employment Service to: Office of Workforce Security
" "	1128	" "	from: Office of Job Corps to: Office of Youth Services
Change	1307	State	from: Bureau of Near Eastern & S Asian Affairs to: Bureau of Near Eastern Affairs
" "	1329	" "	from: Bureau of Intl Narcotics Matters to: Bureau of Intl Narcotics & Law Enforcement
" "	1332	" "	from: Bur of Oceans & Intl Envir & Scientif Aff to: Bur of Oceans, Environment & Science
Change	4150	VA	from: Allen Park VA Hospital to: Detroit VA Medical Center
" "	4186	""	from: Las Vegas Clinic To: Las Vegas VA Medical Center
Change	1363	Judiciary Claims	from: U. S. Claims Court to: Court of Federal

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 the following: four decisions on loss of wage-earning capacity; one decision involving performance of duty; a decision involving the use of an affirmative defense by the Office upon rescinding an acceptance; two decisions addressing refusal of suitable work; and others. If you find, upon reviewing a decision summary, that it affords guidance in a topic that you are addressing, you should obtain the ECAB decision in its entirety for your thorough review.

DEBORAH B. SANFORD
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)

LOSS OF WAGE-EARNING CAPACITY

Lucretia D. Jones, Docket No. 98-991, issued April 20, 2000; Seldon H. Swartz, Docket No. 98-48, issued April 17, 2000; and Francisco Bermudez, Docket 98-1395, issued May 11, 2000

These three decisions concerned whether the LWEC determination fairly and reasonably represented the claimant's wage-earning capacity.

In Lucretia D. Jones, the issue was whether the Office properly determined that the claimant's actual earnings as a modified distribution clerk represented her wage-earning capacity. The claimant's accepted condition was aggravation of osteoarthritis bilaterally. She returned to work after having total knee replacement surgery as a modified clerk for six hours per day. The Board noted that among the considerations to be made in determining whether a position fairly and reasonably represents the claimant's wage-earning capacity are: 1) whether the job is part-time or full-time; 2) whether or not the job is seasonal; and, 3) whether the job is permanent or temporary. In this case, the Board stated that since the claimant had the ability to work a maximum of six hours per day, five days per week, and she was provided with a permanent position within those guidelines, the position fairly and reasonably represented her wage-earning capacity. It therefore found that the finding of suitability by the Office was proper.

The Board affirmed the Office's decision, noting that it had properly determined that the modified clerk position fairly and reasonably represented the claimant's wage-earning capacity.

In Seldon H. Swartz, the claimant was employed as a service technician for the Forest Service and suffered an injury which resulted in a herniated disc at L5-S1. The claimant did not return to employment with the employing agency, but obtained a position as an Education Services Director at an area health education center. The Office used this information to terminate compensation on the basis that his actual earnings exceeded those of his date-of-injury job. When the claimant's place of employment closed down 16 months later, he requested that his compensation be reinstated.

Thereafter, the Office rated the claimant as an MRI technician; however, that decision was remanded by Hearings and Review on the basis that that position was not shown to be reasonably available in the claimant's area. Subsequently, the Office found that the claimant's earnings in the position of Education Services Director fairly and reasonably represented his wage-earning capacity, and that he was not entitled to compensation since his earnings in that capacity would exceed his date-of-injury position.

The claimant contested the decision on the following grounds: 1) that he did not have the experience required for the position; 2) that he never actually performed the duties of the position when he had that job title; and 3) that when the position description and the claimant's

experience were compared, he did not meet the qualifications listed. The Board noted that the claimant's contentions suggest that the duties he performed may have been makeshift work, and as such would clearly not have been representative of his wage-earning capacity.

The Board remanded the case, holding that the Office may not use a possible makeshift position to represent a claimant's wage-earning capacity, unless it demonstrates that this question has been investigated. It also noted that this question will be more closely scrutinized when the Office applies the LWEC determination to a period after the employee no longer works in the position selected. The Board directed remand for the Office to address the claimant's contention that the position of education services did not fairly and reasonably his wage-earning capacity.

In Francisco *Bermudez*, the Office determined the claimant's WEC was represented by the position of cashier. The claimant had been a 57-year-old emergency firefighter in 1990 when he sustained a facial contusion, laceration of the eyebrow, and left shoulder strain in the course of his employment. He incurred permanent residuals due to his work injury from musculoligamentous strain affecting the left shoulder.

Approximately a year later the Office initiated vocational rehabilitation efforts. However, this was hampered due to the claimant's inability to speak or understand English, his intelligence quotient on psychological testing, and his extremely limited education (one year of formal schooling in Mexico). The claimant was enrolled in a one-year English as a Second Language (ESL) course. The period of the claimant's English training was extended for an extra 4 months due to his poor progress. Subsequently, the claimant was enrolled in a cashiering training course which also included ESL.

Six years later the Office reduced compensation based on the determination that the position of cashier/checker fairly and reasonably represented the claimant’s wage-earning capacity. He had not performed or progressed well according to his instructor at the training center, who also indicated that she did not think that further training would make any difference.

Upon review, the Board found that the WEC determination was improper, stating that the Office had failed to meet its burden to justify reduction of benefits. The Board also noted that the medical evidence the Office had relied on to show that the claimant was capable of performing the duties of cashier was nearly three years old, and that the position description provided to the doctor at that time was not consistent with the description used to reduce compensation. The Board concluded that the Office had failed to give due regard to the factors enumerated under § 8115 of the FECA in determining the claimant's wage-earning capacity. The Board reversed the decision and remanded the case, directing that the Office clarify the claimant's employment status and pay rate for compensation purposes.

These three decisions emphasize the following points: 1) WEC determinations should be made with due regard to the claimant’s maximum ability to work and the permanency of the position offered; 2) if the position description upon which the WEC is based in not consistent with the

actual duties of the position, the Office should consider whether the position was makeshift; 3) due consideration should be given to the claimant's education and experience when selecting a position for a WEC determination; and 4) the selected DOT position must be consistent with the medical restrictions.

LOSS OF WAGE-EARNING CAPACITY

Darryl Leggett, Docket No. 98-1531, issued April 4, 2000

In this case the claimant had been a 42-year-old motor vehicle operator when he sustained a work-related injury that was accepted for lumbar sprain/strain.

After several courses of physical therapy and more than a year later, the case was referred to vocational rehabilitation. When it was found that the employing agency had no limited duty for the claimant, assistance in a job search was initiated. Vocational and psychological testing indicated that the claimant could perform the duties of the position of cashier I and II. After approximately seven months, the rehabilitation counselor stated that the placement effort had been unsuccessful and closed the file, indicating that the job of cashier was reasonably available in the Philadelphia commuting area. Thereafter, the Office computed the claimant's constructed wage-earning capacity as a part-time cashier and proposed reduction of benefits accordingly. In the final decision, the Office weighed the medical evidence and noted that the position fairly and reasonably represented the claimant's wage-earning capacity.

On affirming the decision, the Board found that the Office had met its burden to reduce benefits, and had made a proper LWEC determination. The Board noted that the Office had followed its own procedures by, first, contacting the employing agency to attempt returning the claimant to a limited capacity in his prior employment. When that was unsuccessful the claimant was referred to rehab, was given psychological and vocational testing, and was assisted in a job search. When the foregoing was unsuccessful, the Office had proposed reduction of compensation via a constructed LWEC based on the weight of the medical evidence indicating that the claimant could perform the duties of the selected position.

DETERMINING PAY RATE

Walter L. Neitzel, Docket No. 98-1442, issued April 26, 2000

In this case, the Board remanded decision with respect to the claimant's pay rate for compensation purposes.

The claimant had been a 58-year-old field representative when he sustained a work-related neck strain and left shoulder impingement. In determining the claimant's pay rate, the Office initially noted that he was a permanent part-time employee who had worked 27 weeks in the year prior to the employment injury. The information had been obtained from a CA-1030 partially completed by the employing agency; the employer had failed to complete the portion of the CA-1030 which provided the annual earnings of a similar employee in the same kind of appointment. The Office derived the claimant's average earnings by dividing 52 into the total wages earned for the 27 weeks.

The Board stated that the FECA provides for different methods of computation of the average annual earnings depending on the circumstances of the case. Section 8114(d) of the Act provides three methods for determining average earnings. The first subsection, 8114(d)(1), is to be used when the employee had worked substantially the whole year preceding the injury in the date-of-injury job. If the salary was fixed, the average annual earnings are the actual rate of pay. However, if the salary was not fixed the average annual earnings is derived by multiplying the daily wage by 300, 280 or 260, depending on whether the claimant worked a 6-day, 5½-day or 5-day workweek.

The second method, described in subsection 8114(d)(2), applies when the claimant had not worked for substantially the whole year, but when the job held would have afforded employment for the whole year, had it not been for the injury. In this situation, the average annual earnings are equal to those of an employee of the same class working in the same or similar employment for substantially the whole year.

The Board also described the method applied in the third subsection, 8114(d)(3), to be used when neither (1) nor (2) could be applied reasonably and fairly. In such a situation the Board stated:

> "(T)he annual earnings are a sum that reasonably represents the annual earning capacity of the injured employee in the employment in which he was working at the time of injury having regard to the previous earnings of the employee in federal employment, and of other employees of the United States in the same or most similar class working in the same or most similar employment in the same or neighboring location, other previous employment of the employee, or other relevant factors. However, the average annual earnings may not be less than 150 times the average daily wage the employee earned in the employment during the days

employed within 1 year immediately preceding his injury."

On review of the case, the Board held that the Office had not adequately applied the standards of section 8114(d) of the FECA in determining the claimant's pay rate. The Board stated that, given the circumstances of the case, the Office should have applied section 8114(d)(3) to determine the claimant's pay rate. The Board noted that if the Office had considered any of the factors delineated in 8114(d)(3), it would have pursued getting the employer to complete the portion of form CA-1030 which requests information regarding the annual earnings of another employee with the same kind of appointment and working in a job with the same or similar duties. The Board added that the Office did not fully comply with its procedural requirements to obtain adequate information concerning the factors delineated in section 8114(d) of the Act.1 In addition, the Board found that the Office failed to consider previous earnings, prior non-federal employment, and possible full-time work with another employer.

PAY RATE FOR COMPENSATION PURPOSES – LEARNER'S CAPACITY

Carolyn M. Bosley, Docket No. 99-28, issued April 20, 2000___

In this case, the claimant's work injury resulted in a left trapezoid strain and a cervical spine strain, and compensation was paid based on her date-of-injury pay rate. The employing agency terminated her employment four months after the injury on the basis that she was unable to perform the duties of the position.
Subsequently, the claimant contended that the Office should have based compensation on the salary she received upon her career appointment as a Mail Processor, which occurred on June 29, 1991, since she was in a learner's capacity at the time of her work injury. Thereafter, the Office found that the claimant had not been in a learner's capacity at the time of her injury, as she was not enrolled in a formal training program with a specified period for completion followed by an automatic promotion.

The district office decision, which had been affirmed by Hearings and Review, was also upheld by the Board. The Board noted that the Act, in Section 8113(a), provides as follows:

> "If an individual – (1) was a minor or employed in a learner's capacity at the time of injury; and (2) was not physically or mentally handicapped before the injury; the Secretary of Labor, on review under section 8128 of this title after the time the wage-earning capacity of the individual would probably have increased but for the injury, shall recompute prospectively the monetary compensation payable for disability on the basis of an assumed monthly pay corresponding to the probable wage-earning capacity."

The Board also described the circumstances delineated in its prior decisions, which include the following: 1) whether the employee was in a formal training program; 2) whether the job classification described an "in-training" or learning position; 3) whether the position held was one in which the employee could have remained indefinitely; and 4) whether any advancement would have been automatic, or contingent upon ability, past experience or other qualifications.

The Board found that the claimant had not established that she was in a formal training program at the time of her injury, and pointed out that the employer had not offered her the casual appointment as training, but instead as an opportunity for her to demonstrate her rehabilitation. Furthermore, the Board stated that 8113(a) contemplates an increase in compensation in the event that the work injury prevents the employee from obtaining a higher-paying position at the end of a training program. In the present case, the claimant was not prevented from obtaining higher pay by her employment injury, and for that reason alone, the Board stated that § 8113(a) of the Act does not apply to her situation.

SCHEDULE AWARD – INCLUDING PRE-EXISTING IMPAIRMENT TO VISION

Mike Reid, Docket No. 98-2593, issued June 9, 2000

This claim was accepted for a corneal abrasion with scarring in the left eye. Payment was issued for 100% permanent impairment to the left eye, based on an uncorrected visual acuity of 20/200.

After payment of the schedule award, new evidence was submitted that showed the claimant's low visual acuity pre-existed the work injury and remained unchanged. The Office modified the prior award, granting 10% impairment due to injury-related ocular deformity interfering with visual function, based on page 209 of the AMA *Guides to the Evaluation of Permanent Impairment* (fourth edition 1993).

The Board found that the *Guides* require combining the 10% injury-related impairment in visual function with the claimant's pre-existing impairment of visual acuity to determine the total percentage of loss of function of the eye. The Board reversed the award modification, noting that the initial calculation of 100% permanent impairment was correct.

PERFORMANCE OF DUTY – IMPACT OF STATE DECISION REGARDING TERMINATION

Lynda Moore, Docket No. 99-771, issued June 22, 2000

A claim for an emotional condition was filed, alleging overwork, discrimination, and employer abuse in administrative and personnel matters. The claim was denied on the basis that no compensable factor of employment was established. An Office hearing representative upheld the decision.

To support an allegation of wrongful termination, the claimant submitted a decision from the Illinois Department of Employment Security regarding her entitlement to unemployment insurance benefits. The decision found that she was not fired for "misconduct" as defined under the applicable state statutory authority.

The Board found that the state agency's decision did not establish that the termination action itself was erroneous or abusive. Rather, the Board found that the state standard of "misconduct" was limited to the issue of entitlement to unemployment benefits and did not constitute probative evidence of error or abuse. The Office's prior decisions were affirmed.

AFFIRMATIVE DEFENSE – USE IN RESCINDING ACCEPTANCE

Patricia McKibben (widow of Jimmy McKibben), Docket No. 00-452, issued June 9, 2000

A claim for death benefits was filed, contending that the employee's death in a one-car motor vehicle accident while traveling to an employment-related meeting was work related. The claim was accepted.

New evidence was later submitted to show that the employee was intoxicated when the accident occurred. The Office rescinded acceptance of the claim on the basis that the employee's intoxication removed him from performance of duty at the time of the accident.

The Board reversed this decision, stating that intoxication can only be invoked as an affirmative defense under section 8102(a) during the original adjudication of the claim. As the Office did not invoke an affirmative defense at the time of initial adjudication, it is precluded from doing so at a later time. The Board held that the employee's death occurred in the performance of duty.

PENALTY PROVISION § 8106(C) – REFUSAL OF SUITABLE WORK

Alfredo Mata, Docket No. 98-1269, issued May 19, 2000

In this case, the issue was whether the Office's termination of compensation for refusal of suitable work was proper.

The claimant was a 37-year-old letter carrier who suffered contusions to his head and back, and sprains to his neck and right wrist when he slipped in a soap spill in the employees' bathroom. The Office paid compensation on the basis of TTD for a period and then paid compensation for the hours not worked once the claimant returned to work at four hours per day. Four years thereafter, the claimant's treating physician found that he had permanent restrictions which included working no more than four hours a day.

The employing agency offered the claimant a permanent position that was within the restrictions imposed by his treating orthopedic surgeon, but on returning to work, he claimed increased pain and work related stress. The employing agency revised the duties several times to comply with new job restrictions imposed by the claimant's physician, but he refused to sign the job offer. Due to the claimant's relocation four years earlier, his physician found that the commuting distance of 80 miles one-way would be too great. Subsequently, the Office proposed to terminate TTD for the period commencing June 10, 1992, holding that the claimant had not shown a worsening of his condition during that period. The claimant was allowed 30 days to accept the position or provide reasonable justification for his refusal. When the claimant subsequently provided the reason that three physicians had restricted him from traveling more than 20 miles to work, the Office advised him that his reason for refusal was not justified, and allowed him another 15 days to accept the offer without penalty. When the claimant offered substantially the same reason for refusing the position, the Office terminated his benefits accordingly.

On affirming the termination, the Board pointed out that the distance of the drive to the offered position was not considered, since the commute would have been by the claimant's choice.2 The Board noted that the only relevant factors were that the claimant remained on the rolls of the employing agency and that he moved away from the commuting area after his employment injury. It added that a move, even to seek less expensive housing, is not sufficient reason for refusal of suitable work. The Board has held on numerous occasions that an employee's move out of the commuting area is not an acceptable reason for refusal.3 In this instance, the Board ruled that the Office properly terminated compensation in accordance with the provisions of § 8106(c)(2).

PENALTY PROVISION § 8106(C) – REFUSAL OF SUITABLE WORK

Ruggiero A. Pignotti, Docket No 99-190, issued May 15, 2000

In this case, the claimant was a 67-year-old retired motor vehicle operator who had sustained an employment injury which resulted in a torn right rotator cuff and two shoulder surgeries.

Six months following the second surgery, the employing agency offered the claimant a limited-duty position as a modified motor vehicle operator based on the physical restrictions imposed by his treating physician. When the claimant refused the position, he stated that he had decided to retire and that his physician had found him to be permanently disabled.

Upon review of the case, the Board found that the Office had properly terminated the claimant's benefits under the penalty provisions of § 8106(c) for refusing an offer of suitable work. The Board noted that under those provisions, the Office must justify termination by 1) demonstrating through medical evidence that the position is suitable, 2) advising the claimant of its finding that the work offered is suitable and offering the claimant an opportunity to show that the refusal of such work was reasonable or justified, and 3) advising the claimant that the reasons given for failure to accept the offer were not considered justification. The Board added that once the above is done, the claimant must be given another opportunity to accept the offer of employment, i.e., the position must remain open and available to the claimant for at least 15 more days. On the basis that the Office had satisfied all the requirements of due process, the Board affirmed the decision noting that it had properly terminated the claimant's wage-loss compensation. The Board further stated that a claimant's election to receive retirement benefits was not a reasonable justification for refusal of the job.

FECA CIRCULAR NO. 01-05 **October , 2001**

SUBJECT: SELECTED ECAB DECISIONS FOR JULY - SEPTEMBER, 2000

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

The subjects addressed include: timely filing of an appeal; reconsideration - non-merit review; refusal of suitable employment; schedule award - hearing loss; schedule award - maximum medical improvement; wage-earning capacity - constructed position.

DEBORAH B. SANFORD
Director for

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)

APPEALS - TIMELY FILING

Curtis A. Hobbs, Docket No. 1997-1776, Issued August 24, 2000

The issue in this case was whether the Office properly found that the claimant's request for reconsideration was not timely filed and failed to present clear evidence of error.

On April 2, 1997, the claimant filed a claim for occupational disease for a bilateral hearing loss. By decision dated September 19, 1997, the Office denied the claim on the grounds that the claimant had not submitted medical evidence sufficient to establish that his hearing loss was caused by factors of his federal employment. In a letter received by the Office on Monday, September 21, 1998, the claimant requested reconsideration and submitted a copy of an October 15, 1997 report from a physician who opined that the claimant's hearing loss was consistent with noise exposure during his federal employment. By decision dated March 15, 1999, the Office found that the claimant's request for reconsideration was untimely and that the evidence submitted did not establish clear evidence of error.

The Board noted that the Office's most recent merit decision was issued on September 19, 1997 and the claimant was required to file his request for reconsideration by September 19, 1998. However, because that date fell on a Saturday, a non-business day, the claimant's one-year deadline for requesting reconsideration was extended to the next business day, i.e. Monday, September 21, 1998.

Consequently, the Board set aside the Office's decision and remanded the case for proper consideration of the claimant's timely filed reconsideration request.

RECONSIDERATION - NON-MERIT REVIEW

Granville O. Allen Docket No. 1998-0735, Issued August 4, 2000

In this case, the issue under consideration by the Board is whether the Office abused its discretion in refusing to reopen the claimant's case for a merit review. In an October 24, 1997 letter, the claimant inquired about the status of his request for reconsideration submitted on July 24, 1997. He indicated that he had submitted documentation that established his claim when he submitted the July 1997 request for reconsideration, ninety (90) days had elapsed since his request and he had not received a decision. In support of his status request the claimant submitted a postal express mail receipt showing that he had sent something to the Office in July 1997. The Office treated the October 1997 letter as a request for reconsideration. The Office denied the request without a merit review of the record on the grounds that it neither raised substantive legal questions nor included new and relevant medical evidence and, thus, was insufficient to warrant review of the prior decision.

The Board remanded this case for additional development ruling that the Office erred by issuing its findings based on an incomplete record. The evidence allegedly submitted by the claimant in July 1997 was not present in the case at the time of the decision and the Office failed to request this information prior to issuing its decision.

Since the claimant had submitted evidence in support of his allegation that he had previously requested reconsideration that included additional evidence in support of his claim, the Office was obligated to solicit that additional evidence prior to issuing its decision on the claimant's request for reconsideration.

REFUSAL OF SUITABLE EMPLOYMENT

Veronica L. Fiorentino, Docket No. 1999-1252, Issued August 3, 2000

There are two issues before the Board in this claim. However, the issue of interest pertains to the decision of whether the Office properly terminated the claimant's entitlement to compensation on the grounds that she refused an offer of suitable work. The claimant sustained a work related injury on January 25, 1998. The Office accepted that the claimant sustained lumbosacral, left shoulder, left ankle and bilateral knee sprains, and contusions to the abdomen and chest.

On June 1, 1998, the claimant's attending physician released her to work with restrictions. On July 1, 1998, the employing agency offered the claimant employment within the restrictions set forth by her attending physician. On July 2, 1998, the Office found the position suitable and advised the claimant that she had thirty (30) days to accept the position or show good reason for not doing so. On July 15, 1998, the claimant notified the employing agency that she was refusing the offered position. In support of the refusal, the claimant provided a medical report from her attending physician indicating that she was totally incapacitated due to a "herniated disc, L5-S1".

By decision dated August 18, 1998, the Office terminated the claimant's compensation benefits finding that she had failed to respond to the Office's July 2, 1998 letter and that the medical evidence provided to the employing establishment was insufficient to justify her refusal of the position based on the fact that the physician provided no rationale for his conclusions and a herniated disc was not an accepted employment condition.

The Board reversed the Office's decision in this case stating that, the Office's procedures provide that if medical reports in the file document a condition which has arisen since the compensable injury and this condition disables the claimant from the offered job, the job will be considered unsuitable, even if the subsequently acquired condition is not work related.

SCHEDULE AWARD - HEARING LOSS

Jeffrey J. Stickney, Docket No. 1999-1659, Issued August 7, 2000

In this case, the issue under consideration by the Board is whether the Office properly calculated the claimant's entitlement to a schedule award for a 7% binaural hearing loss.

The Office accepted that the claimant sustained an employment-related binaural hearing loss. The medical evidence established that the claimant has a 43% monaural hearing loss in his left ear, a 0% monaural hearing loss in his right ear and a 7% binaural hearing loss.

The Board cited FECA Program Memorandum No. 181 (issued November 26, 1974) which provides "On occasion, the allowances for loss of hearing in each ear, if computed separately, may be greater than the combined value of bilateral hearing loss." In such cases, the claimant should be given the benefit of the more favorable allowance.

In this case, the claimant's monaural hearing loss, when calculated separately, equates to 22 weeks of compensation as opposed to 14 weeks of compensation for the 7% combined binaural loss.

The Board modified the Office's decision to reflect the claimant's entitlement to the additional eight (8) weeks of compensation based on the monaural hearing loss calculation.

SCHEDULE AWARD - MAXIMUM MEDICAL IMPROVEMENT/AUGMENTED COMPENSATION RATE

Mark P. Brown, Docket No. 1999-0585, Issued August 2, 2000

There are two issues before the Board in this claim. However, the issue of interest pertains to the decision of whether the claimant is entitled to payment of his schedule award at the augmented rate.

On August 27, 1997 the claimant filed a claim for a schedule award, listing his dependent as his "girlfriend". An August 6, 1997 medical report provided an impairment rating and found that the claimant reached maximum medical improvement on August 6, 1997. The Office medical adviser, in a report dated August 19, 1997 concurred with the finding of August 6, 1997 as the date of maximum medical improvement.

In a letter dated January 5, 1998, the claimant advised the Office that his son had been his dependent until June 1997. He requested augmented compensation on the grounds that he would have filed for a schedule award while his son was still a dependent had he known that he was entitled to an award.

By decision dated February 12, 1998, the Office found that the claimant was not entitled to the augmented compensation rate because his son was not his dependent on August 6, 1997, the date he reached maximum medical improvement.

In July 1998, the claimant requested reconsideration and resubmitted an April 6, 1995 work capacity evaluation from his attending physician who listed the date of maximum medical improvement as April 6, 1995. The Office denied the claimant's request for reconsideration on the grounds that the evidence submitted was irrelevant and insufficient to warrant review of the prior decision.

In the instant case, the claimant had a dependent son until June 1997. His schedule award began on August 6, 1997, the date the Office determined that the medical evidence established that he had reached maximum medical improvement. On appeal, the claimant contended that the Office incorrectly set the date of maximum medical improvement.

The Board affirmed the Office's decision stating

> The Office generally establishes the date of maximum improvement as the date that appellant was medically evaluated for purposes of making a schedule award. In the instant case, the Office set the date of maximum medical improvement and thereby the date on which the period of the schedule award would begin, as August 6, 1997, the date of appellant's impairment evaluation. Both Dr. Boehle, appellant's physician who evaluated him for schedule award purposes, and the

Office medical adviser, who reviewed Dr. Boehle's report, found that appellant had reached maximum medical improvement on August 6, 1997. While Dr. Taylor, another attending physician, indicated in a work restriction evaluation dated April 6, 1995 that appellant reached maximum medical improvement on that date, he did not evaluate appellant for purposes of determining impairment for a schedule award. Therefore, the opinions of Dr. Boehle and the Office medical adviser constitute the weight of the medical evidence and establish that appellant reached maximum improvement on August 6, 1997. As appellant did not have a dependent on that date, he is not entitled to compensation at the augmented rate.

WAGE EARNING CAPACITY - CONSTRUCTED POSITION

Beverly A. Berry, Docket No. 1999-1691, Issued August 11, 2000

In this case, there are two issues under consideration by the Board. The issue of interest is whether the Office properly reduced the claimant's compensation based on its determination that the selected position of receptionist represented her wage-earning capacity.

The Office accepted that the claimant sustained a work related injury on June 21, 1996, resulting in a cervical and lumbar strain as well as herniated discs at C3-7. The Office denied the claim that her depression and anxiety conditions were related to the June 21, 1996 work injury. The Office noted that the claimant had pre-existing asthma and bipolar disorder and was involved in a non-work related motor vehicle accident in February 1997.

The Office determined that the position of receptionist represented the claimant's wage-earning capacity as of April 26, 1998. The Board reversed this decision.

The Board noted that, while the Office acknowledged that the claimant had a pre-existing condition of bipolar disorder, the Office knowingly excluded this information from consideration when selecting a position that ostensibly reflected appellants' vocational wage-earning capacity. The record indicates that the Office specifically instructed the rehabilitation specialist to identify appropriate positions that were based solely on appellant's orthopedic limitations. This directive was clearly contrary to the Office's procedure manual.

When the evidence of record supports that a medical condition pre-existed the work injury, the Office must establish work restrictions for that condition as well as any of the medical conditions accepted as resulting from the work injury.

In this case, although the claimant failed to establish that her depression and anxiety conditions were related to the work injury, the bipolar disorder pre-existed the work injury. Therefore, the Office was obligated to establish, not only orthopedic work restrictions, but also psychiatric work restrictions based solely on the bipolar disorder.

FECA CIRCULAR NO. 01-06

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

The interest rate to be assessed for prompt payment bills is 5.875 percent for the period July 1, 2001 through December 31, 2001.

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 interest rate for assessing interest charges on debts due the Government remains 6.0 percent for the period from January 1, 2001 through December 31, 2001.

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

DEBORAH B. SANFORD
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

7/1/01 - 12/31/01	5 7/8%
1/1/01 - 6/30/01	6 3/8%
7/1/00 - 12/31/00	7 1/4%
1/1/00 - 6/30/00	6 3/4%
7/1/99 - 12/31/99	6 1/2%
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%

FECA TRANSMITTALS (FT)--INDEX

FT 01-02	**Checklist, Federal (FECA) Procedure Manual (01/01A)**
FT 01-03	**Revision to Chapters 2-901, Computing Compensation, and 2-401, Automated System Support for Case Actions (02/01B)**
FT 01-04	**Revision to Chapter 2-900, Determining Pay Rates**
FT 01-06	**Revision to Chapter 2-810, Developing and Evaluating Medical Evidence**
FT 01-08	**Revision to Chapter 0-0100, Introduction to FECA and DFEC, Federal(FECA) Procedure Manual**

FECA TRANSMITTALS (FT)--TEXT

FECA Transmittal No. 01-01 **November 6, 2000**

RELEASE – REVISION TO CHAPTER 4-0300, WAR HAZARDS, PART 4 – SPECIAL CASE PROCEDURES, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 3 is updated to show the 1999 and 2000 yearly increases under the Longshore and Harbor Workers' Compensation Act.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
4	4-0300	i Ex. 3	4	4-0300	i Ex. 3

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, Rehabilitation Specialists, and Staff Nurses)

EXPLANATION OF MATERIAL TRANSMITTED:

This release transmits the current checklist for the Federal (FECA) Procedure Manual. The checklist is a comprehensive accounting of all Procedure Manual pages issued as of September 30, 2000. The previous checklist, issued October 5, 1998, and all transmittal sheets through No. 00-11 may be discarded. This current checklist should be retained at the front of the Procedure Manual, with transmittal sheets after No. 00-11.

DEBORAH B. SANFORD
Acting Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
	Previous checklist			Current checklist	

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)

PROMPT PAYMENT INTEREST RATES

1/1/01 - 6/30/01	6 3/8%
7/1/00 - 12/31/00	7 1/4%
1/1/00 - 6/30/00	6 3/4%
7/1/99 - 12/31/99	6 1/2%
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

1/1/01 - 12/31/01	6%
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 TRANSMITTAL NO. 01-03 **January 30, 2001**

RELEASE - REVISION TO CHAPTERS 2-901, COMPUTING COMPENSATION, AND 2-401, AUTOMATED SYSTEM SUPPORT FOR CASE ACTIONS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 2-401 and 2-901 are revised to clarify the requirements for certification and verification of compensation payments. Chapter 2-901, Exhibits 1, 2, and 3 are updated to include the recent minimum, maximum and CPI amounts.

Chapter 2-901.3 is revised to clarify the requirement that all payment set-ups, except routine

daily roll payments, must be initialed and dated by the certifier before the payment is issued. Further revision to this paragraph makes it clear that certification and verification are separate tasks. The verifier's initials and date must appear on the CP040 print-out prior to the cut-off date. This paragraph is also updated to reflect the fact that all GS-12 Claims Examiners now have the certification authority previously reserved for Senior Claims Examiners.

Where a payment has to be revised or re-entered after the initial keying, the certifier is responsible for updating the TPCUP program. This requirement is specifically stated in paragraphs 2-401.10a and 2-401.10c. The reference to Form CA-8 is deleted from this paragraph, also. Paragraph 2-401.3 is revised to indicate that the CE refers any change of address to the designated individual rather than making the change themselves.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-901	i,3-6	2	2-901	i,3-6
		Ex 1, p. 3-4			Ex 1, p. 3-4
		Ex 2, p. 3-4			Ex 2, p. 3-4
		Ex 3			Ex 3
2	2-401	i,1, 17-20	2	2-401	i,1, 17-20

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. 01-04 **April 26, 2001**

RELEASE— REVISION TO CHAPTER 2-900, DETERMINING PAY RATES

EXPLANATION OF MATERIAL TRANSMITTED:

The calculation of weekly payrate using the 2087 formula was erroneously outlined in the last paragraph of 2-900-10(c)(2). This paragraph has been modified to correct this error.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-900	i, 23 24	2	2-900	i, 23 24

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. 01-06

RELEASE— REVISION TO CHAPTER 2-810, DEVELOPING AND EVALUATING MEDICAL EVIDENCE

EXPLANATION OF MATERIAL TRANSMITTED:

The requirement that a note be entered for initial physical therapy authorization has been removed, as has the erroneous reference to the need for a proposed termination prior to denial of physical therapy for any period beyond that authorized.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-810	i, ii, 33-36	2	2-810	i, ii 33-36

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. 01-08

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

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 2, which contains addresses and telephone numbers for all district offices, requires frequent revision. In recent years, this information has been available to OWCP staff via the Intranet and to external users via the program's web site. Because electronic changes are easier and faster to make, and because the paper version of this information is now redundant, Exhibit 2 is being removed from this chapter. A reference to finding the addresses and telephone numbers on the program's web site has been added to paragraph 3c.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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Part	Chapter	Pages	Part	Chapter	Pages
0	0-0100	i 1-2 Ex. 2	0	0-0100	i 1-2

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

OWCP BULLETINS (OB)--INDEX

OB 01-01 **OASIS - Retention Schedule for Paper Documents (02/01B)**
Attachment 1 - OASIS DOCUMENT AUDIT WORSHEET
Attachment 2 - OASIS BACKLOGGED DOCUMENT AUDIT WORKSHEET

OWCP BULLETINS (OB)--TEXT

OWCP BULLETIN NO. 01-01

Issue Date: February 21, 2001

Expiration Date: February 21, 2002

Subject: OASIS - Retention Schedule for Paper Documents

Background: In FY 2000 DFEC began deploying a new imaging system in its district offices. OWCP Automated System for Imaging Services (OASIS), changes the process by which case files are handled by DFEC staff. This system was developed to provide DFEC staff with an electronic case file to use in place of a paper file. Once OASIS is activated in a district office, every new claim created is processed using this system. All case file documents for these claims are captured and stored electronically and the claims examiner adjudicates and manages them exclusively in the electronic environment.

However, at this time most case file related documents are still received in the district offices in paper form. Once the document has been captured and stored electronically, the paper document is no longer necessary for the development and management of the case as the electronic image becomes the official record. Since the deployment of OASIS, each district office has stored the paper documents pending quality review and disposal schedules for these materials.

Reference: OWCP Procedure Manual Chapter 1-0300

Purpose: To notify district offices of the retention schedule and audit requirements for paper documents after input has been made into OASIS.

Applicability: Regional Directors, District Directors, Assistant District Directors, Chiefs of Operations, Systems Managers, Technical Assistants, and National Office Staff.

Action:

On-going Imaged Material

1. The paper copy of all OASIS imaged material must be retained for ninety (90) days from the date of receipt.

2. An audit of documents is required to ensure that documents belonging to OASIS-processed cases are being properly imaged and associated with the appropriate case file and that the imaged documents are of an acceptable quality.

3. The person(s) assigned to perform the audit must be claims personnel. 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 list must be updated immediately as changes in this responsibility occur.

4. The audit must be performed on a weekly basis and the documents to be sampled must be identified prior to the document preparation stage.

5. Ten (10) documents must be sampled from the incoming mail batches (including medical mail batches). The documents to be sampled should not include CA-1, CA-2, CA-2a, CA-7 forms or medical bills.

6. In addition, one (1) to two (2) documents from incoming faxes must be sampled.

7. If the mail flow of the district office is such that certain types of documents are received/opened/reviewed first by someone other than the mail room staff and the mail is then returned to the mail room for routine OASIS handling, one (1) to two (2) documents from each of these other sources must be sampled.

8. Additionally, two (2) to three (3) documents must be sampled from internally created documents. (Transfer batches should be excluded from this sampling.)

9. When a document is selected to be sampled, the auditor must annotate the OASIS Document Audit Worksheet. (See Attachment 1.) The auditor enters the date of receipt, the file number, and a brief description of the document.

10. One (1) week to two (2) weeks later, the auditor will attempt to locate the sampled document in OASIS. The results must be entered on the OASIS Document Audit Worksheet. The auditor will note whether the electronic version of the sampled document was found in OASIS, if the imaged document was readable, and if the file number was correct, and will then initial and date the entry.

11. All OASIS Document Audit Worksheets must be maintained by the District Director in a central location.

12. If the sampling reveals problems with either the document control or image quality, the Director for FEC should be notified and immediate corrective action must be taken by the district office.

13. If no problems result from the sampling, all imaged documents for the week sampled may be destroyed after ninety (90) days have elapsed from the date of receipt.

Backlog of Imaged Material

1. Since no imaged documents have been destroyed as of this date, there is a backlog of stored documents for several district offices. An audit of these stored documents must be performed prior to their destruction.

2. A one-time audit of all stored documents more than one (1) week old at the time of the implementation of this bulletin must be performed prior to their destruction.

3. The person(s) assigned to perform the audit must be claims personnel. The District Director must maintain a list of all claims staff authorized to perform this audit of backlogged material.

4. For each month, four (4) C-closures must be sampled. In the case of C-closures only, the auditor must locate in OASIS and inspect all documents contained in the paper file.

5. Additionally, six other documents must be sampled for each month. The auditor should pull six batches that were processed during the month being sampled. The batches should have been processed on different days of the week. From the pulled batches, the auditor must choose one (1) document each from the beginning of two (2) batches, from the middle of two (2) batches and from the end of two (2) batches.

6. When a document is selected to be sampled, the auditor must annotate the OASIS Backlogged Document Audit Worksheet. (See Attachment 2.) The auditor enters the time period being audited and, the date of receipt, the file number, the position in the batch (i.e. beginning, middle or end) or C-closure, and a brief description of the document.

7. The auditor will then attempt to locate the sampled document in OASIS. The results must be entered on the OASIS Backlogged Document Audit Worksheet. The auditor will note whether the electronic version of the sampled document was found in OASIS, if the imaged document was readable, and if the file number was correct, and will then initial and date the entry.

8. Each sampled period must be documented by completion of the OASIS Backlogged Material Audit Worksheet. The worksheets must be retained by the District Director in a central location.

9. If the sampling reveals problems with either the document control or image quality, the Director for FEC should be notified and immediate corrective action must be taken by the district office.

10. If no problems result from the sampling, all imaged documents for the month sampled may be destroyed after ninety (90) days have elapsed from the date of receipt.

The destruction of all paper file material should be accomplished in accordance with district office policy on the destruction of case files.

Disposition: Retain until the indicated expiration date.

CECILY A. RAYBURN
Acting Director, Division of
Planning, Policy and Standards

Distribution: List No. 3-Folioviews Group D
Regional Directors, District Directors, and National Office Staff

Attachment 1 - OASIS DOCUMENT AUDIT WORSHEET

Attachment 2 - OASIS BACKLOGGED DOCUMENT AUDIT WORKSHEET

OWCP CIRCULARS (OC)--INDEX

OWCP CIRCULARS (OC)--TEXT

OWCP TRANSMITTALS (OT)--INDEX

OT 01-01 **Revisions to Chapter 1-400, FOIA and Privacy Act, Part 1 - Administration (12/00A)**

OWCP TRANSMITTALS (OT)--TEXT

OWCP TRANSMITTAL NO. 01-01 **November 1, 2000**

RELEASE - REVISIONS TO CHAPTER 1-400, FOIA AND PRIVACY ACT, PART 1 - ADMINISTRATION, FEDERAL (OWCP) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

The ability to transmit information electronically has greatly improved the speed and ease of communications within OWCP, and also between OWCP and interested parties such as employing agencies. However, this method of transmission requires special safeguards to ensure that information protected by the Privacy Act is not compromised. New paragraph 13 is added to this chapter to describe how e-mails outside OWCP should be structured so as to maintain the confidentiality of information about claimants and beneficiaries.

E-mail messages within OWCP–-those exchanged between parties in a given office, or between two offices–-do not require the same level of care as those traveling outside of OWCP, since they are protected by an electronic “firewall”. However, as with all other letters or notes pertaining to case files, every employee should use tact and prudence in e-mail correspondence. The information sent should be limited to the amount needed to convey the intended message, and superfluous comments should be avoided.

CECILY RAYBURN
Acting Director, Division of
Planning, Policy and Standards

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Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
1	1-0400	i, 19	1	1-0400	i, 19

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