BCT-FY02

This infobase contains a numerical index of all **FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 2002**, as well as the text of these issuances.

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

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FECA BULLETINS (FB)--TEXT

FECA BULLETIN NO. 02-02

Issue Date: March 1, 2001

Expiration Date: February 28, 2002

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 2001.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 2001.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 3.4 percent.

2. The increase is effective March 1, 2001, and is applicable where disability or death occurred before March 1, 2000.

3. The new base month is December 2000.

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

$ 6,476.44 per month
1,494.56 per week
5,978.24 each four weeks
298.91 per day (for a 5-day week)

Applicability: Appropriate National Office and District Office personnel.

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

Action: On or about March 14, 2001, both the periodic disability and death payrolls were updated in ACPS. No supplemental record was created for cases with gross overrides. Thus, the cases with gross overrides must be reviewed to determine if CPI adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustment Dates.

a. As the effective date of the CPI is March 1, 2001 and the start date of the periodic and death payroll cycles was February 25, 2001,a supplemental record was created for the period March 1 through March 24, 2001. Effective March 25, 2001, the periodic and death payrolls reflect the increased amount.

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

2. CPI, Minimum and Maximum Adjustments Listings.

Form CA-841, Cost-of-Living Adjustments; Form CA-842, Minimum Compensation Rates; and Form CA-843, Maximum Compensation Rates, should be updated with the new information. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966 through March 1, 2001.

3. Forms.

a. The benefit statement sent to each individual receiving benefits on the 28-day periodic roll for the roll cycle from March 25, 2001 to April 21, 2001 has been updated. The benefits statement provides the gross amount of compensation, the period of compensation covered by the statement, and the pertinent deductions made from the gross compensation. For compensation payments made via paper checks, the benefit statement will accompany the check. For compensation payments made through Electronic Fund Transfer (EFT),the benefit statement will be mailed separately.

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

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

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

possible. Thus, a simple letter indicating the

amount of compensation paid every four weeks will be an adequate substitute for this purpose.

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

DEBORAH B. SANFORD
Director, Federal Employees' Compensation

Attachment

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

COST-OF-LIVING ADJUSTMENTS

Under 5 USC 8146(a)

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	09/01/80	4.0%
01/01/68	3.7%	03/01/81	3.6%
12/01/68	4.0%	03/01/82	8.7%
09/01/69	4.4%	03/01/83	3.9%
06/01/70	4.4%	03/01/84	3.3%
03/01/71	4.0%	03/01/85	3.5%
05/01/72	3.9%	03/01/87	0.7%
06/01/73	4.8%	03/01/88	4.5%
01/01/74	5.2%	03/01/89	4.4%
07/01/74	5.3%	03/01/90	4.5%
11/01/74	6.3%	03/01/91	6.1%
06/01/75	4.1%	03/01/92	2.8%
01/01/76	4.4%	03/01/93	2.9%
11/01/76	4.2%	03/01/94	2.5%
07/01/77	4.9%	03/01/95	2.7%
05/01/78	5.3%	03/01/96	2.5%
11/01/78	4.9%	03/01/97	3.3%
05/01/79	5.5%	03/01/98	1.5%
10/01/79	5.6%	03/01/99	1.6%
04/01/80	7.2%	03/01/00	2.8%
		03/01/01	3.4%

Prior to 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.23 on a weekly basis ($.23, $.46, $.69, or $.92). After 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a "periodic" basis or the nearest $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).

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

.81-.07 = .92 .88-.12 = 1.00

FECA BULLETIN NO. 02-03

Issue Date: January 31, 2002

Expiration Date: January 30, 2003

Subject: Case Management -Authorization of Physical Therapy

Background: Physical therapy is one of the most common medical services authorized under the Federal Employees' Compensation Act (FECA). Nearly 25% of injured federal workers receive at least one physical therapy modality as part of their treatment. During FY 2000, physical therapy dollars constituted 13% of all medical outlays.

Currently, cases with physical therapy costs exceeding $8,000.00 per year make up 1% of all cases in which therapy is authorized. However, this 1% of cases is responsible for 11% of the total physical therapy costs paid under the FECA.

Reference: FECA Procedure Manual Chapter **2-810-16**.

Purpose: To establish clear guidance on the proper authorization of physical therapy services and to transmit new procedures for the regular review of high cost physical therapy cases.

Applicability: Claims Examiners, Senior Claims Examiners, Claims Supervisors, Staff Nurses, Fiscal Officers, Technical Assistants, Bill Resolution Staff, Hearing Representatives, and Hearing Examiners.

Action:

Initial Authorization of Physical Therapy

1. Physical therapy that is prescribed by the attending physician and performed within the first 120 days followingthe date of injury (DOI), date of authorized surgery or date of accepted recurrence should be approved if the accepted medical condition(s) warrants it, i.e. orthopedic or neurologic condition accepted. The claimant should be notified via acceptance letter of the period during which physical therapy services are authorized. The CE must be

specific regarding the dates during which physical therapy is authorized.

a. The occupational disease acceptance letter, CA-1008OD found in the DFEC Letter Generation System under the Acceptance and Medical Authorization/Denial category, has been modified to require the inclusion of specific dates during which physical therapy treatment is authorized if that option is selected. The CA-1008 for traumatic injury claims was not modified. It continues to include an optional paragraph stating that physical therapy is authorized for a period of up to 120 days from the date of injury.

b. A recurrence acceptance letter has been added to the DFEC Letter Generation System under the Acceptance and Medical Authorization/Denial category. This letter contains an optional paragraph to authorize physical therapy and requires the inclusion of specific dates during which the services are authorized.

c. The letter authorizing surgery, CA-6059 found in the DFEC Letter Generation System under the Acceptance and Medical Authorization/Denial category, has been modified to address the authorization of physical therapy services and requires the inclusion of specific dates during which the services are authorized.

1. Physical therapy services provided during the first 120 days following the DOI for a traumatic injury or occupational disease, with an appropriate accepted medical condition, will continue to be processed for payment without CE intervention. The CE must enter the authorized 120 day period in screen #34, PHYSICAL THERAPY AUTH of the Case Management File (CMF) for accepted recurrences, periods following authorized surgery or any other events that fall outside of the 120 days from the DOI window. *As a rule, previous authorization periods should not be overwritten or removed. If more than two authorization periods are required, the CE should overwrite the older period. However, this overwritten period must be entered into screen #12, NOTE of the CMF.*

2. Extended physical therapy may be approved for severe brain or spinal cord injuries, extensive second or third degree burns or other severe injuries that have rendered the claimant bedridden permanently or for an extended period of time. The CE may authorize physical therapy services for up to one year in these circumstances. However, the accepted condition(s) must support this exception.

Physical Therapy Requests After the Initial Authorization Period

1. Physical therapy should not be routinely authorized for periods longer than 120 days when the accepted conditions are sprains and strains or other self-limiting musculoskeletal conditions.

2. When physical therapy is requested beyond the initial 120 day period, the CE should evaluate the evidence of record and the projected period and frequency of the additional physical therapy request based on the guidelines described in PM **2-0810-16**.e. The CE may wish to utilize the district medical advisor (DMA) in assessing the medical evidence.

3. Prior to authorization of any additional physical therapy, the file must contain medical evidence that provides the following:

    a Diagnosis for which physical therapy will be administered.
    b. Specific functional deficits that are to be treated, including a description of how these affect the patient's physical activities.
    c. Specific functional goals of the additional therapy.
    d. Expected duration and frequency of treatment.
    e. Modalities, procedures and/or tests and measures to be administered as detailed by the Physicians' Current Procedural Terminology (CPT) codes.
    f. Appropriateness of a patient-directed home exercise program as an alternative to supervised physical therapy.

4. Necessary medical development may be undertaken in one of the following ways:

    a. Release of a physical therapy development letter to the treating physician. The DFEC Letter Generation System contains letter CA-6021 for this purpose. (This letter has been revised and is found in the Development/Medical Category of the Letter Generation System.) Both the claimant and physical therapy provider should be copied when the development letter is sent.
    b. Second opinion evaluation.
    c. Development by a Field Nurse (FN) if one is currently assigned.

5. If the medical evidence of record clearly supports the additional period, or a minimal (less than two week) period of additional therapy is requested, the CE may authorize additional physical therapy for the period requested or 90 days, whichever is less.

6. Authorization for additional physical therapy treatment must not be granted and no further physical therapy can be paid until the development of this issue is complete.

Assessment of Medical Evidence

1. The CE should review the evidence obtained to determine if the requested period of PT is

deemed appropriate. Section 5 U.S.C. 8103 of the Federal Employees' Compensation Act (FECA) permits approval of services "likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation". For most cases, 120 days of physical therapy is sufficient to satisfy the requirements of section 8103. For requests exceeding this amount of treatment, the CE is charged with ensuring the medical evidence contained in the file justifies how the additional physical therapy will benefit the injured worker within the parameters of section 8103. The evidence should be sufficient to allow an independent reviewer to ascertain the specific nature of the expected cure, relief or reduction in disability. The medical evidence should be assessed critically to ensure it clearly supports not only the benefits of the expected therapy, but the specific extent and duration of the additional treatment.

2. In determining the need for additional therapy the CE should weigh the medical evidence using the following criteria:

    a. The physical therapy is directed to the accepted condition or to an accepted complication of this injury or condition, including surgery; and
    b. The specific modalities, procedures and/or tests and measures include some form of active physical therapy as evidenced by the use of any of the following CPT codes: 97110 through 97116 (therapeutic exercises); 97240 through 97241 (pool therapy or Hubbard tank); 97500 through 97541 (orthotics, prosthetics and activities of daily living training); and
    c. A functional deficit exists and the additional therapy is expected to produce some functional improvement. Pain alone does not constitute a functional deficit. To authorize additional physical therapy for pain, the CE should ensure that the pain is associated with measurable objective findings such as muscle spasm, atrophy and/or radiologic changes in joints, muscles or bones, or that pain has placed measurable limitations upon the claimant's physical activities.

Approving Additional Physical Therapy

1. If medical justification for additional physical therapy is sufficient, the CE should issue a letter indicating the specific period of authorization. The CE should notify the claimant, the treating physician and the physical therapy provider of the specific period of the extension. CA-6021 in the DFEC Letter Generation System can be used for this notification.

2. If the authorized period is shorter than the period requested, the letter should explain the basis for the limited authorization.

3. The additional period of authorized physical therapy treatment should not exceed 90 days.

4. The CE must update screen #34 in the CMF with the additional authorized period of physical therapy.

Denying Additional Physical Therapy

1. If the medical evidence of record is not sufficient to support the need for additional physical therapy, the CE should notify the claimant as to why the benefit cannot be granted. The prescribing physician and the physical therapy provider should be copied with this letter. This letter should not contain appeal rights.

2. Any request by the claimant for a formal decision on the denial of the additional physical therapy should be granted. (PM **2-1400**.2a.(2)).

3. No pre-termination notice is required if the claimant was notified of the specific authorized period, i.e. 120 days from the DOI, date of recurrence or date of surgery, and any specified period of extension, and physical therapy is not paid for any period other than that actually authorized in writing. In this circumstance, OWCP has not led the claimant to expect that payment for the service will continue.

Alternative Approaches to Supervised Physical Therapy

1. Often physical therapists can instruct patients in home exercise programs or other types of self-directed exercise to achieve or preserve the functional goals of the physical therapy program. When presented with a request for additional physical therapy, the CE should explore whether the claimant is ready to transition to a self-directed home or gym exercise program.

2. In reaching this determination, the CE should carefully consider the efficacy of past supervised therapy and the magnitude of any expected functional improvement.

3. Developmental requirements for health facility membership and special equipment can be found in PM **2-810-15**. The DFEC Letter Generation System contains development letters

for health facility membership and in-home therapy equipment. (See CA-6042, CA-6043 and CA-6044.)

Chiropractic and Osteopathic Manipulative Treatment

1. If a spinal subluxation has been accepted, manual manipulation of the spine by a chiropractor is payable. However, other physical therapy services, even if performed by a chiropractor, are subject to the requirements described above.

2. When the treating physician prescribes manipulative treatment by a chiropractor or an osteopathic physician, this therapy is subject to the above procedures.

3. Physical therapy services provided by a chiropractor or osteopath must be recommended and directed by the treating physician.

Changes to the Federal Employees' Compensation System (FECS)

1. A new edit code, 380L, has been added to the Bill Processing System (BPS).
    b. This limits payment of CPT-4 code 97001 (initial physical therapy evaluation) to one time per year.
    c. This edit is set to deny without the possibility of override.
    d. The Explanation of Benefits description is as follows: INITIAL PHYSICAL THERAPY EVALUATIONS ARE LIMITED TO ONE PER YEAR. THIS SERVICE HAS BEEN PROVIDED IN THE LAST 365 DAYS. FOR FURTHER CONSIDERATION, RESUBMIT BILL WITH MEDICAL JUSTIFICATION AND A COPY OF THIS NOTICE.

2. Some additional physical therapy edits will be added to the BPS early in 2002.
    b. The BPS will limit payment of manual manipulation services to "R" type providers.
    c. If no subluxation medical condition has been accepted, manual manipulation services furnished by an "R" type provider will pay only if prior authorization has been entered in screen #34, PHYSICAL THERAPY AUTH of the CMF.
    d. All physical therapy services, other than manual manipulation services, furnished by an "R" type provider will pay only for periods of prior authorization entered in screen #34, PHYSICAL THERAPY AUTH of the CMF.

CE Review of High Cost Physical Therapy Cases

1. On approximately the tenth of every month, each district office will be provided with a Physical Therapy High Cost Cases Report for their office.

2. The list will include cases in which the physical therapy costs over the past 12 months are in the top 1% of physical therapy costs nationally and in which payment for a physical therapy

treatment has been made within the last 90 days.

3. The report will list the responsible CE, case number, claimant's name, total physical therapy costs paid under this claim number during the last 12 months, CPT code(s) from the last payment made, provider type of the last provider paid, EIN and address of the last provider paid. **(See Attachment 1.)**

4. The responsible CE (or designated person) should carefully review the case file and ensure that the therapy being provided is appropriate and necessary. At the time of the initial review of each claim appearing on the high cost report, an Initial Evaluation Report must be completed and returned to the National Office coordinator for compilation and analysis of statistics. This should be accomplished electronically. Only one initial evaluation report is required per case. (See Attachment 2.)

5. If the case record does not support the need or benefit of continued therapy, the CE should utilize the PT High Cost Letter to query the prescribing physician on the effectiveness of the current program and on alternatives to supervised therapy. This is a new letter that has been added to the DFEC Letter Generation System under Miscellaneous/Physical Therapy.

6. Use of a second opinion evaluation is encouraged in these cases in order to independently confirm the need for continued therapy.

7. The responsible CE (or designated person) will be responsible for completing a Final Disposition Report at the point the physical therapy issue has been resolved. This report should be returned to the National Office coordinator for compilation and analysis of statistics. This should be accomplished electronically. If no development is being undertaken and the reason is described on the Initial Evaluation Report, a Final Disposition report is not required. (See Attachment 3.)

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)

Attachment 1

PHYSICAL THERAPY HIGH COST CASES REPORT District Office
Link to Image

Attachment 2

_____ _____
(Claimant's Name) (Case File #)

_____
(Date)

INITIAL EVALUATION REPORT OF HIGH COST PT CASES

1) Is the case being excluded from development because a subluxation has been accepted and the attending physician is a chiropractor and the only therapy procedures being paid are either manual manipulation (CPT-4 codes 98940-98943) or office visits (CPT-4 codes 99201-99215)?
Yes _____

2) Is the case being excluded from development because the accepted condition(s) is a severe brain or spinal cord injury, extensive second or third degree burns or other severe injury that has rendered the claimant bedridden permanently or for an extended period of time?
Specify condition(s):
_____

3) Is the case being excluded from development because the claimant received PT services only during the initial approval period of 120 days from:
Date of injury - Traumatic: _____
OD: _____
Date of authorized surgery (show date): _____
Date of accepted recurrence (show date): _____

4) Show all condition(s) for which physical therapy is being administered (based on evidence of record):
_____
_____

5) Does the claimant have a pre-existing, non-work related medical condition?
Specify condition(s):
_____

6) Describe PT development initiated in this case.
Release of PT High Cost Letter (date released): _____
Referral for SECOP/IME (date referred): _____
Other explain): _____

7) If no PT development is being initiated for a reason other than those listed above, please provide an explanation of why development is not required.
_____
_____
_____
_____

Attachment 3

FINAL DISPOSITION REPORT OF HIGH COST PT CASES

1) The attending physician determined no further physical therapy was required. (Provide date PT stopped.) _____

2) Physical therapy authorization was terminated as the medical evidence of record failed to support a continuing need.
Informal denial letter sent. (Show date.): _____
Formal decision issued. (Show date.): _____

3) Physical therapy was terminated as a result of SECOP/IME. (Provide date of formal decision.) _____

4) Some form of self-directed therapy was authorized in lieu of on-going directed therapies. Describe the form of self-directed therapy authorized, i.e. home equipment or fitness center membership. (Include type of equipment authorized.)
_____
_____

5) All compensation and/or medical care was terminated as the evidence of record supported no continuing residuals of the accepted condition. (Show date of formal decision.) _____

6) Other. Provide explanation. _____

FECA BULLETIN NO. 02-04

Issue Date: January 14, 2002

Expiration Date: January 2003

Subject: Revised procedures for processing work-related injury claims filed by employees of the Office of Workers' Compensation Programs and their relatives in the Midwest (formerly Chicago) Region.

Background: Current procedures for Mail and File require that all cases filed by employees of the Office of Workers' Compensation Programs and their relatives are under the jurisdiction of the Kansas City district office for adjudication and case management. The Kansas City district office is now assigned to the Midwest Region. The Midwest Region now includes Illinois, Indiana, Michigan, Minnesota, Wisconsin, Ohio, Iowa, Kansas, Missouri, and Nebraska. Therefore, procedures for adjudicating and maintaining injury compensation claims involving employees of the Office of Workers' Compensation Programs and their relatives must be revised. OWCP claims outside the Midwest Region will continue to be processed in the Kansas City district office (except Job Corps).

Reference: Federal (FECA) Procedure Manual, Chapter 1-200-2(g)2 and Chapter 1-200-2(l).

Purpose: To transfer jurisdiction for all claims filed by employees of the OWCP and their relatives originating in the Midwest Region (Illinois, Indiana, Michigan, Minnesota, Wisconsin, and Ohio) from the Kansas City district office (District 11) to the National Operations Office (District 25).

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

Action:

1. Effective immediately, all claims for work-related injuries filed by OWCP employees and their relatives in the Midwest Region are under the jurisdiction of and should be filed in the National Operations Office (District 25).

2. The Kansas City district office (District 11) will forward all existing case files, that involve OWCP employees and their relatives living and/or working in the Midwest Region to the National Operations Office (District 25) for maintenance and handling.

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,B,C,D (Regional Directors, District Directors, Claims Examiners, All Supervisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA BULLETIN NO. 02-05

Issue Date: January 14, 2002

Expiration Date: January 31, 2003

Subject: Comp Pay/ACPS – Employing Agency Action to Notify DFEC of Claimant Ineligibility for Continuing Life Insurance.

Purpose: To furnish instructions on new Office of Personnel Management (OPM) guidance to employing agencies regarding determinations of continuing eligibility for life insurance.

Applicability: Appropriate National Office and District Office personnel.

Reference: FECA PM Part 5, Chapter 5-400(11)(a). OPM Procedures are detailed in OPM BAL Number 01-216 dated August 21, 2001.

Background: Agencies ordinarily notify DFEC of what type(s) of life insurance the employee has by means of a CA-7 (Claim for Compensation On Account of Traumatic Injury or Occupational Disease); DFEC withholds the FEGLI premiums accordingly from the individual's compensation. Employees who are receiving workers' compensation benefit payments may continue their Federal Employees' Group Life Insurance (FEGLI) coverage if they meet OPM's Five-Year/All-Opportunity requirement as of the date they start receiving compensation. Claimants that do not meet OPM's Five-Year/All-Opportunity requirement are still entitled to remain insured as an employee for up to 12 months in a non-pay status, or separation from federal service, whichever comes first. At that point the employing agency must make an eligibility determination and notify DFEC accordingly. It is the responsibility of the employing agency to notify both OPM and DFEC of any change in the claimant's entitlement to FEGLI coverage.

Action: For those claimants where it is clear that they will not meet OPM's Five-Year/All-Opportunity requirement, the employing agency must notify DFEC. This notification is necessary to ensure that optional life insurance withholdings can be appropriately stopped at the end of 12 months in non-pay status (or separation, if that happens first). In order to notify DFEC, the agency must complete a Notice of Life Insurance Ineligibility (copy attached). This form will be sent to the district office at the same time the Form CA-7 is submitted.

In addition to sending the Notice of Life Insurance Ineligibility to DFEC, a copy will be sent to the claimant. This will notify the claimant that the FEGLI coverage will terminate upon separation or completion of 12 months in non-pay, whichever comes first. The claimant will also be notified that they have the right to convert the coverage upon termination of FEGLI coverage.

The claims examiner will place a call-up in the system to indicate that life insurance premiums must be stopped at the end of 12 months of non-pay or separation.

Disposition: This Bulletin is to be retained in Part 5, Benefit Payments, Federal (FECA) Procedure Manual, until further notice or 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, District Medical Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, and Rehabilitation Specialists)

FECA BULLETIN NO. 02-06

Issue Date: January 31, 2002

Expiration Date: January 31, 2003

Subject: Compensation Pay: Compensation Rate Changes Effective January 2002

Background: In December 2001, the President signed an Executive Order implementing a salary increase of 3.60 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only includes the 3.60 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, 2002.

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, 2002. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $107,357 per annum. The basis for the minimum compensation rates is the salary of $16,592 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, 2002	Minimum	Maximum
Monthly	$1,037.00	$6,709.81
Weekly	239.31	1,548.42
Daily(5-day week)	47.86	309.68

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

for death is computed to $1,037.00, effective January 2, 2002. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $6,709.81 per month.

Applicability: Appropriate National and District Office personnel

Reference: Memorandum for Directors of Personnel dated December 2001; and the attachment for the 2002 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 27, 2002, there will be no supplemental payroll necessary for the periodic disability and death payrolls.

    b. The new minimum/maximum compensation rates will be available in ACPS on or about January 21, 2002.

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, 2002. 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 – 01/02/02

47.86-71.79 239.31-358.96 47.86 239.31(959.24) 1,037.00
47.86-63.82 239.31-319.08

CA-843 – 01/02/02

309.68 1,548.42(6,193.68) 6,709.81

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. 02-07

Issue Date: March 1, 2002

Expiration Date: February 28, 2003

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 2002.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 2002.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 1.3 percent.

2. The increase is effective March 1, 2002, and is applicable where disability or death occu before March 1, 2001.

3. The new base month is December 2001.

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

$ 6,797.04	per month
1,568.55	per week
6,274.20	each four weeks
313.71	per day (for a 5-day week)

Applicability: Appropriate National Office and District Office personnel.

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

Action: On or about March 14, 2002, both the periodic disability and death payrolls will be updated in ACPS. If there are any cases with gross overrides, there will be no supplemental record created. Thus, the cases with gross overrides must be reviewed to determine if CPI adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustment Dates.

a. As the effective date of the CPI is March 1, 2002 and the start date of the periodic and death payroll cycles is February 24, 2002, there will be a supplemental record created for the period March 1 through March 23, 2002. Effective March 24, 2002, the periodic and death payrolls will reflect the increased amount.

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

2. Adjustments of Daily Roll Payments. Since the CPI will not be in ACPS until March 17, 2002, daily roll payment cases requiring the new CPI should be held for data entry until that date. *ACPS RECORDS THAT REQUIRE ADJUSTMENT SHOULD NOT BE ENTERED BETWEEN MARCH 14, 2002 AND MARCH 17, 2002.* ACPS data entry may resume on March 18, 2002.

3. CPI, Minimum and Maximum Adjustments Listings. Form CA-841, Cost-of-Living Adjustments; Form CA-842, Minimum Compensation Rates; and Form CA-843, Maximum Compensation Rates, should be updated with the new information. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966 through March 1, 2002.

4. Forms.

a. Beginning with the compensation payment cycle that covers March 24, 2002 to April 20, 2002, the Office will issue an updated monthly Benefit Statement to each individual receiving benefits on the 28-day periodic roll cycle. This Benefit Statement will state the gross amount of compensation, the period of compensation covered by the statement, and the pertinent deductions made from the gross compensation. For compensation payments made via paper checks, the Benefit Statement will accompany the check. For compensation payments made through Electronic Fund Transfer (EFT), the Benefit Statement will be mailed separately.

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

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

d. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification; insurance verification; loan application; etc.), please provide this data in letter form from the district office. Many times a benefit statement may not reach the addressee, and regeneration of the form is not possible. Thus, a simple letter indicating the amount of compensation paid every four weeks will be an adequate substitute for this purpose.

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

DEBORAH B. SANFORD
Director, Federal Employees' Compensation

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

Attachment

COST-OF-LIVING ADJUSTMENTS

Under 5 USC 8146(a)

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	03/01/81	3.6%
01/01/68	3.7%	03/01/82	8.7%
12/01/68	4.0%	03/01/83	3.9%
09/01/69	4.4%	03/01/84	3.3%
06/01/70	4.4%	03/01/85	3.5%
03/01/71	4.0%	03/01/87	0.7%
05/01/72	3.9%	03/01/88	4.5%
06/01/73	4.8%	03/01/89	4.4%
01/01/74	5.2%	03/01/90	4.5%
07/01/74	5.3%	03/01/91	6.1%
11/01/74	6.3%	03/01/92	2.8%
06/01/75	4.1%	03/01/93	2.9%
01/01/76	4.4%	03/01/94	2.5%
11/01/76	4.2%	03/01/95	2.7%
07/01/77	4.9%	03/01/96	2.5%
05/01/78	5.3%	03/01/97	3.3%
11/01/78	4.9%	03/01/98	1.5%
05/01/79	5.5%	03/01/99	1.6%
10/01/79	5.6%	03/01/00	2.7%1
04/01/80	7.2%	03/01/01	3.4%1
09/01/80	4.0%	03/01/02	1.3%

Prior to 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest multiple of $.23 on a weekly basis ($.23, $.46, $.69, or $.92). After 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on a "periodic" basis or the nearest $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).**1(1)**

Prior to 11/1/74 .08-.34 = .23
.35-.57 = .46
.58-.80 = .69
.81-.07 = .92

Eff. 11/1/74 .13-.37 = .25
.38-.62 = .50
.63-.87 = .75
.88-.12 = 1.00

FECA BULLETIN NO. 02-08

Issue Date: February 5, 2002

Expiration Date: February 5, 2003

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

Background: Effective January 21, 2002, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobile has increased to 36.5 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, this rate will also apply to individuals covered by the FECA who travel by POV in order to obtain 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. Vouchers being processed for travel periods after January 21, 2002 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

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

Attachment 2

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 to June 6, 1996	30.0 cents per mile
June 7, 1996 to September 7, 1998	31.0 cents per mile
September 8, 1998 to March 31, 1999	32.5 cents per mile
April 1, 1999 to January 13, 2000	31.0 cents per mile
January 14, 2000 to January 21, 2001	32.5 cents per mile
January 22, 2001 to January 20, 2002	34.5 cents per mile
January 21, 2002 and after	36.5 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.

FECA BULLETIN NO. 02-10

Issue Date: June 14, 2002

Expiration Date: June 14, 2003

Subject: Bill Payment-Physical Therapy Multiple Initial Evaluations

Background: Edit code 380L was added to the Bill Processing System (BPS) to limit payment of CPT-4 code 97001 (initial physical therapy evaluation) to one time per year. This edit is set to automatically deny without the possibility of override. The Explanation of Benefits advises that the medical provider can resubmit the bill with medical justification for further consideration of payment (see FECA Bulletin 02-03). Medical providers are now presenting valid reasons for the use of the 97001 code more than one time per year. Since CPT-4 Code 97001 is allowed payment only one (1) time a year this inhibits the payment of medical providers following further consideration. The use of another code prevents the application of the fee schedule and duplicate edits. Additionally, there is no established system for monitoring these transactions.

A new OWCP Program-Specific Code has been developed to assist district offices in making payment in those cases that are medically justified for more than one initial physical therapy evaluation in a year.

Reference: FECA Procedure Manual Chapter 2-810-16, FECA Bulletin NO. 02-03 and FECA Procedure Manual Part 5.

Purpose: To notify district offices of the OWCP Program-Specific Code used only in cases in which more than one (1) initial physical therapy evaluation is medically justified within a year.

Applicability: Claims Examiners, All Supervisors, System Managers, District Medical Advisors, Mail and File Personnel, Fiscal and Bill Pay Personnel, Staff Nurses, Technical Assistants, Hearing Representatives and Hearing Examiners.

Action:

1. A new OWCP Program-Specific Code, PT2IE, (physical therapy second initial evaluation) payment for multiple PT Initial Evaluations has been added to the Procedure File (V30) in all district offices.

2. All provider requests for further consideration for the use of 97001 should be referred to the district office's medical coding specialist or other designated staff member (Assistant District Director, fiscal or bill processing personnel, FECA PM Part 5).

3. The medical coding specialist or other staff member will assess the validity of the request. Situations that require a second initial physical therapy evaluation within a one (1) year timeframe include: a newly accepted consequential injury, surgery, and claimant referral to another health provider for evaluation.

4. Should the service be considered payable, the reviewer will re-process the bill. The reviewer will use PT2IE instead of the original 97001. There will be limited use of this code. The designated reviewer will provide instruction in the notes that the bill is approved for payment processing.

5. If the service is not deemed payable, the reviewer should notify the provider that the service is not payable by the program.

6. Training should be done by an appropriate staff member within thirty (30) days. This item will be viewed as part of the physical therapy standards and will be subjected to case review in upcoming Accountability Reviews.

Disposition: Retain until the indicated expiration date.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

Distribution: List NO.2-Folioviews Group A,B and C (Claims Examiners (including Seniors), All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, Staff Nurses, Fiscal and Bill Pay Personnel)

FECA CIRCULARS (FC)--INDEX

Attachments

FC 02-06	Attachment **1 Prompt Payment Interest Rates** Attachment **2 DMS Interest Rates**
FC 02-07	Attachment 1 **Prompt Payment Interest Rates** Attachment 2**DMS Interest Rates**

FECA CIRCULARS (FC)--TEXT

FECA CIRCULAR NO. 02-01

SUBJECT: DUAL BENEFITS - FERS COLA

Effective December 1, 2001, Social Security Benefits will increase by 2.6%. That requires the amount of the FERS Dual Benefits Deduction to be increased by the same amount.

This adjustment will be made from the National Office and will affect all cases that are correctly entered into the ACPS Program. The adjustment will be made effective with the periodic roll cycle beginning December 2, 2001. No adjustment will be made for December 1, 2001.

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, 2001	2.6%
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. 02-03 **November 30, 2001**

SUBJECT: SELECTED ECAB DECISIONS FOR OCTOBER – DECEMBER, 2000

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

The subjects addressed include: compensation – reinstatement of benefits; earnings – self-employment; fact of injury – inconsistent facts; medical opinions – clarification and impartial medical examination; overpayments; performance of duty – altercations and deviation from route; reconsideration – merit review, non-merit review and timely filing; recision of acceptance; recurrence; time limitation – occupational disease; wage earning capacity – actual earnings and medical evidence.

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)

COMPENSATION - REINSTATEMENT OF BENEFITS

Emanuel J. Piturro, Docket No. 99-345, Issued November 29, 2000

In this case, the Office terminated the claimant's compensation and medical benefits because he no longer had any continuing disability due to his accepted employment injury. The Office determined that the medical evidence of record supported the basis for termination.

The claimant subsequently requested reconsideration of this decision and submitted additional medical evidence in support of that request. The Office determined that this additional medical evidence created a conflict in the medical evidence and arranged for the claimant to be examined by an impartial medical examiner. Relying upon the medical opinion of the impartial medical examiner, the Office found that the claimant no longer had any disability due to his accepted employment injury.

The Office did not re-instate compensation or medical benefits at the point that a conflict of medical evidence was determined to exist.

The Board affirmed this decision stating that "Once the Office accepts a claim and pays compensation, it has the burden of justifying modification or termination ... of compensation benefits. The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment. The Office's burden includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background." The Board found that the initial termination decision was proper based on the evidence of record at the time the decision was issued.

The Board further noted that "After termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation benefits shifts to appellant. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence that he had an employment-related disability, which continued after termination of compensation benefits." The Board found that the Office properly identified a conflict of medical evidence subsequent to the original termination of benefits. Based on the impartial medical examiner, any subsequent disability was properly denied.

EARNINGS - SELF-EMPLOYMENT

Kyu Kelly, Docket No. 99-1636, Issued October 4, 2000

The issue in this case was whether the Office properly determined the claimant's loss of wage-earning capacity for the period beginning February 18, 1997.

The Office found the claimant's earnings as a self-employed accounting service business owner fairly and reasonably represented her wage-earning capacity.

The Board notes, however, that the Office "did not use appellant's earnings in this position, which appellant had occupied since December 1994, as the basis of her wage-earning capacity. Instead, the Office used the amount appellant estimated it would have cost her to hire someone to perform her position, $10.00 per hour. Even though an Office rehabilitation specialist indicated that $10.00 per hour was in the range of salaries for the position of office manager or administrative assistant and that these positions were available in appellant's commuting area, the Office's decision was erroneous."

The Board went on to explain "Under section 8115 of the Act, wage-earning capacity must be determined either by using actual earnings or by selecting an available position in the open labor market that the claimant is physically and occupationally able to perform. The Office cannot make a wage-earning determination based on what another person would have earned if he or she had worked the hours that the claimant did in his or her actual position. Although the Office's decisions in the present case purported to use appellant's actual earnings as the basis of her wage-earning capacity beginning February 18, 1997, appellant's actual earnings, as reflected

by her income tax return from 1997, appear less than the $400.00 per week used by the Office."

The Office's decision was reversed.

EMOTIONAL CONDITIONS - PERFORMANCE OF DUTY - CHANGE IN DUTY SHIFT

Mark Kapanowski, Docket No. 99-1975, Issued October 2, 2000

The issue in this case was whether the claimant met his burden of proof in establishing that he developed an emotional condition due to factors of his federal employment. This decision contains an interesting discussion of 'change' in existing duty shift.

> "In this case, appellant attributed his emotional condition to a proposed change in his work schedule. On January 30, 1998 the employing establishment provided appellant with notice that on January 31, 1998 he would be converted to a full-time flexible clerk with a schedule of 8:30 a.m. to 5:00 p.m. with regular days off of Wednesday and Thursday. Appellant stated that his normal work hours were Monday through Friday from 7:00 a.m. to 3:30 p.m. with Saturday and Sunday as regular days off.

The Board notes that the present case does not involve 'change' in appellant's existing duty shift. The Board has recognized that working a rotating or fluctuating shift or a reassignment made to a different shift schedule may constitute a factor of employment in determining whether an injury has been sustained in the performance of duty. However, a proposed shift change that has not been implemented is not compensable under the Federal Employees' Compensation Act. In this instance, appellant's shift was not altered from a day to night shift such that his sleep patterns would be disturbed. Instead the employing establishment proposed to promote appellant and consequently alter his work schedule by an hour and a half per day. Furthermore, appellant did not actually attempt the change in work hours prior to filing his claim. For these reasons, the Board finds that appellant has not establish (sic) that his change in work hours constituted a compensable factor of employment."

FACT OF INJURY - INCONSISTENT FACTS

Ellerton Spruiell, Docket No. 00-136, Issued December 21, 2000

The issue in this case was whether the claimant sustained an injury in the performance of duty as alleged.

The claimant filed a notice of traumatic injury, alleging that he injured his back when he fell at work. The employing agency controverted the claim on the grounds that the fall was idiopathic.

The claimant was assigned to clean out a walk-in storage box that was filled with various materials including hazmat, clothing, wooden pallets, tires, etc. He alleged that he caught his

foot on something, probably a pallet, and fell. He did not remember much until the rescue squad began giving him oxygen. The narrative statement from the claimant's supervisor supported the essential elements of the claimant's allegations.

The Office denied the claim for failure to establish the factual elements of fact of injury noting that the medical evidence contained three different histories of injury, none of which coincided with the history provided by the claimant on the CA-1, Notice of Traumatic Injury.

The Board found that the factual evidence of record was sufficient to establish that the claimant experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The Board noted that "While appellant's account of the events of June 4, 1998 is largely confirmed by his supervisor, the physicians who treated appellant on the day of the incident and thereafter, have provided quite differing explanations of the manner in which appellant injured his back. These inconsistencies are not sufficient to impugn the validity of appellant's claim, but they do diminish the probative value of the physicians' opinions relating appellant's injury to his work."

The Board remanded the case for further medical development based on the accepted mechanism of the fall.

MEDICAL OPINIONS - CLARIFICATION

Billy R. Cooksey, Docket No. 99-317, Issued October 3, 2000

The issue in this case was whether the Office properly determined that the selected position of information clerk represented the claimant's wage-earning capacity.

The Board reversed the Office's decision, finding that the impartial medical opinion on which the decision was based, was not sufficiently detailed to establish that the claimant was capable of performing the selected position.

The Board specifically noted that the Office recognized the deficiencies in the referee medical report and requested clarification. However, no additional explanation was received from the referee physician and there was no indication that any physician of record reviewed the job description for information clerk and opined that the claimant was capable of performing the position.

If the Office requests clarification of a medical opinion, it is obligated to obtain that clarification. If the physician from whom the clarification is requested is either unwilling or unable to provide the requested clarification, a new medical examination must be arranged.

MEDICAL OPINIONS - IMPARTIAL MEDICAL EXAMINATION

Marie Niwore, Docket No. 99-2280, Issued October 11, 2000

The issue in this case was whether the claimant sustained more than a 4% impairment of her

right upper extremity.

The Office determined that a conflict in medical opinion existed in this case. The claimant and entire case file were referred to an impartial medical examiner to resolve the conflict.

The Board found that the case was not in posture for a decision due to an unresolved conflict in the medical opinion. They found that the impartial medical opinion of record was improperly obtained and must be excluded from the record.

Specifically, the case file contained evidence of a telephone conversation between the Office medical advisor and the impartial medical examiner, regarding the calculation of the schedule award.

The Board noted that in *Carlton Owens, 36 ECAB 608, 616 (1985)*, it held that oral communication or conversations between the Office and the impartial medical examiner on disputed issues should not occur as it undermines the appearance of impartiality that is crucial to a referee opinion.

In this case, the Board found that the telephone conversation between the Office medical advisor and the impartial examiner raised an appearance of impropriety because disputed issues were discussed. The Office medical advisor "attempted to have the doctor eliminate his evaluation of appellant's index finger, which was part of appellant's claim for a schedule award. As the issue in this case is whether appellant had a permanent impairment of her right upper extremity, a discussion concerning it involves a disputed issue."

The case was remanded for a resolution of the conflict in medical opinion.

OVERPAYMENTS

Lillian Hasz, Docket No. 99-1088, Issued December 7, 2000

The issue of interest in this decision was whether the Office properly denied the claimant's request for waiver of recovery of the overpayment.

In this case, the Board found that the Office correctly determined that the claimant had a $24,472.11 overpayment of compensation. In calculating the total income of the household, the claimant included the wages of her son but asked that those wages not be included in the Office's calculations as he would not continue to work if his grades declined. The Office based its denial of waiver on calculations that included the son's income.

The regulations define income for overpayment calculation purposes as:

> The individual's total income includes any funds, which may be reasonably considered available for his or her use, regardless of the source. Income to a spouse will not be

considered available to the individual unless the spouse was living in the household at the time the overpayment was incurred and at the time waiver is considered.

The Board noted that the Office failed to consider whether the income of the claimant's son (or any other children) was reasonably available to the claimant for her use. If the son's income was not expected to be used to meet any part of her household expenses, then that income should not be considered reasonably available to the claimant.

The Board affirmed the fact and amount of the overpayment but remanded the case for further development as to the amount of income the claimant had available for living expenses. The Board specifically instructed the Office to ask whether any of the claimant's children had income, and if so, whether their income was used to pay the ordinary and necessary living expenses of the household.

PERFORMANCE OF DUTY - ALTERCATION

Leslie C. Moore, Docket No. 00-126, Issued November 1, 2000

The issue in this case was whether the claimant established that he sustained an emotional condition in the performance of duty.

In this case, the claimant filed a claim for a traumatic injury alleging that he was assaulted in the parking lot of his place of employment by a coworker's spouse. The claimant's account of this assault was corroborated by a number of witnesses.

The Office denied the claim, finding that the reason for the attack was due to the claimant's inappropriate comments to his female coworker that had occurred during the workday and, therefore, the resulting incident was not a covered work event.

The Board found that the assault occurred in the course of the claimant's employment. The Board noted that, "The parking lot where the assault occurred is considered to be a part of the employment premises and appellant has, therefore, satisfied the 'course of employment' portion of the performance of duty test. The Board notes, however, that appellant still has to satisfy 'arising out of' portion of the performance of duty test before his injury would be deemed to have occurred in the performance of duty. 'Arising out of the employment' requires that a factor of employment caused the injury."

The Board noted that the "record contains evidence that appellant and Ms. Jackson (coworker) engaged in a quarrel over the performance of employment duties which contributed to the assault. The evidence also establishes that appellant was reasonably fulfilling the duties of his employment at the time of the verbal altercation..." The Board further noted that the Office invoked the affirmative defense of willful misconduct in conjunction with the original adjudication of the claim. The Board noted however, that "such defense will not serve to remove appellant from the performance of duty barring compensation in this case. Although appellant's

responses to his coworker during their exchange were indeed inappropriate, appellant was approached by Ms. Jackson whereby she initiated an altercation due to his response to a question posed by his supervisor who sought to staff an upcoming shift." The Board has previously held that there is no provision in the Act authorizing the denial of compensation because the employee was an aggressor, or the initiator, or otherwise did something "imputing culpability or fault on his part".

The Board, therefore, found that, "as the assault on appellant on employment premises resulted from a dispute, which occurred during appellant's tour of duty and regarded work issues, the assault bears a sufficient relationship with his employment to afford coverage. There is no evidence that the basis for the altercation was imported to the work environment."

PERFORMANCE OF DUTY – DEVIATION FROM ROUTE

Karen Cepec, Docket No. 00-346, Issued December 7, 2000

The issue in this case was whether the claimant's injury arose in the performance of duty and whether the injury resulted from willful misconduct.

The claimant was involved in a motor vehicle accident during working hours. The accident occurred when, following her last delivery, the claimant decided to check out a street on a new route that was to be assigned to her in the near future. The street was approximately two blocks from her current route and the claimant counted houses and tried to find a good place to park her vehicle when the new route began.

The employing agency contended that this unauthorized deviation from her established route removed the claimant from performance of duty. The agency further contended that such deviation was in violation of agency rules and that the claimant was fully aware that such unauthorized deviation from her route was not permitted.

The Office denied the claim finding that the claimant had deliberately violated a known rule and intentionally deviated from her route without permission. The Office further found that this deviation was for personal reasons as her presence in the area was not a condition of her employment, was not required by the employing agency and was not needed to prepare her for her future assignment. In addition, the Office found that the claimant's willful misconduct led to the injury.

The Board reversed the Office's decision. The Board noted that the standard to be used in determining whether an employee has deviated is that, in addition to a person taking a somewhat roundabout route or not taking the most direct route between the place of origin and the point of destination, it must be shown that the deviation was aimed at reaching some specific personal objective.

In this case, the Board found that "it was not established that appellant's deviation from the

normal line of travel was aimed at reaching some specific personal objective. Following her last delivery of the day, the appellant decided to check out the new street on her future route, to count the houses and to find a good place to park her vehicle when the new route began. However unnecessary or even prohibited this conduct may have been, however poor her judgement, the purpose of appellant's conduct was unquestionably related to work. Her departure from the normal line of travel was not such that she can fairly be said to have engaged in personal activities unrelated to her employment." Consequently, the Board found that the claimant's injury arose in the course of her employment.

With respect to the issue of willful misconduct, the Board noted that willful misconduct "is generally regarded as deliberate conduct, involving premeditation, obstinacy or intentional wrongdoing with the knowledge that it is likely to result in serious injury, or conduct which is in wanton or reckless disregard of probable injurious consequences. In the present case, appellant was driving her postal vehicle when the accident occurred. This activity was not different in nature from that in which she was normally engaged and required to perform. The Office has made no showing that appellant knew that her conduct was likely to result in serious injury or that she wantonly or recklessly disregarded probable injurious consequences. For this reason the Board finds that the Office has not met its burden of proving the affirmative defense of willful misconduct."

RECONSIDERATION - MERIT REVIEW

Robert M. Brown, Docket No. 00-653, Issued December 7, 2000

The Office granted the claimant a schedule award for 8% loss of the right ring finger, which amounted to two weeks of compensation.

The claimant's attorney requested reconsideration of the decision arguing that an 8% loss should have been granted and the two weeks of compensation did not accurately represent the findings of the doctor. While the argument of the claimant's attorney was not clearly stated, a review of the medical evidence of record confirmed that the schedule award should have been based on permanent impairment of the right hand rather than solely the right ring finger.

The Office denied the request for review finding that the contention of the claimant's representative was immaterial and insufficient to warrant review.

The Board found that the claimant's representative had advanced a relevant legal argument not previously considered by the Office. Essentially, the Board found that the medical evidence of record included consideration of a permanent impairment to the hand as well as the right ring finger. The schedule award was based solely on the impairment to the right ring finger. Consequently, the argument advanced in support of reconsideration constituted a relevant legal argument requiring a merit review.

RECONSIDERATION - NON-MERIT REVIEW

David Lee Sanders, Docket No. 99-1785, Issued October 24, 2000

The issue in this case was whether the Office abused its discretion in refusing to reopen the claimant's case for further consideration of the merits of his claim.

The claim was accepted for a July 15, 1991 aggravation of epididymitis. The claimant alleged a recurrence of the accepted medical condition effective August 1, 1994. This claim for recurrence was denied because the medical evidence of record failed to support a causal relationship between the accepted July 15, 1991 employment injury and the claimed recurrence. This decision was affirmed by the hearing representative who noted that Dr Schwartzwald, the claimant's treating physician, provided no opinion that the employment-related aggravation became permanent.

In November 1998, the claimant requested reconsideration of this decision and submitted a new report from Dr. Schwartzwald. The Office declined to review the merits of the case finding that the evidence submitted in support of the request for review was cumulative in nature and not sufficient to warrant a merit review of its prior decision.

The Board noted that the requirement for reopening a claim for merit review does not include the requirement that a claimant submit all evidence necessary to discharge his burden of proof. The requirement specifies only that the evidence be relevant and pertinent and not previously considered by the Office. A claimant has the right to secure a review of the merits of his case when he presents new evidence relevant to his contention that the decision of the Office is erroneous. The presentation of such new and relevant evidence creates a necessity for review of the full case record, i.e. of all of the evidence, in order to properly determine whether the newly supplied evidence, considered with that previously in the record, shifts the weight of the evidence in such a manner as to require modification of the earlier decision. If the Office determines that new evidence lacks substantive probative value, it may deny modification of the prior decision, but only after the case has been reviewed on its merits.

In this case, the Board found that the new report from Dr. Schwartzwald provided a level of explanation regarding causal relationship that was not in his prior reports. This rendered the new report relevant and not merely repetitious of prior reports. As such, the evidence warranted a review of the case on its merits.

RECONSIDERATION - TIMELY FILING

Mary Ann P. DeGuzman, Docket No. 99-2319, Issued October 13, 2000

The salient discussion in this decision pertains to when the Board's decision represents a merit review of the case.

The Board noted that, in this case, the Office improperly assumed that the Board's order denying the claimant's petition for reconsideration constituted the last merit decision in the case. While a claimant is allowed an opportunity, by regulation, to petition the Board for reconsideration, such petition for reconsideration, unless granted by the Board, does not constitute a merit review of the case. In addressing the finality of the Board's decisions, the regulation provides:

> The decision of the Board shall be final upon the expiration of 30 days from the date of filing of the order, unless the Board shall in its order fix a different period of time or reconsideration by the Board is granted.

The Board's decision becomes final unless the Board grants a petition for reconsideration and reopens the case. An order by the Board merely denying a petition for reconsideration, which does not grant reopening of the case, does not constitute a merit decision.

RECISION OF ACCEPTANCE

Lavenia E. Bell, Docket No. 98-1813, Issued October 6, 2000

The issue in this case was whether the Office properly rescinded its acceptance of a claim for major depression.

The Board notes that, once the Office has accepted that the claimant's emotional condition arose in the performance of duty, in order to justify rescinding that acceptance, the Office must establish, through new evidence, legal argument or rationale, that the claimant's injury did not arise in the course of employment.

The Office initially denied the claim, finding that the evidence of record failed to establish an injury in the performance of duty. On appeal, the hearing representative found a number of covered factors of employment, namely that the claimant had not been allowed to train others as an on-the-job instructor, that negative statements concerning the claimant's performance were not supported by evidence and that the claimant reacted to events she deemed discriminatory. The hearing representative further found that the medical evidence of record supported that work factors caused her to become depressed and anxious. Consequently, the claim was accepted for major depression.

The claimant then filed a claim for recurrence of disability. The employing agency offered new evidence denying the factors of employment found in performance of duty. The Office reopened the claim for further review and found that the claimant failed to substantiate her allegations of discrimination and the evidence failed to establish that the employing agency erred or acted abusively in performing administrative matters. On appeal, the hearing representative found that the claimant had not submitted sufficient evidence to establish discrimination by employing agency personnel, that management mishandled the EAP referral or that the employing agency acted unreasonably in the administration of personnel matters.

The Board found that the evidence demonstrated that the employing agency had adequate reasons for not allowing the claimant to train others on-the-job, that the claimant's referral to EAP was an administrative matter and the claimant failed to establish error or abuse on the part of the employing agency

Consequently, the Board found that the Office met its burden to rescind acceptance of the claim based on new evidence submitted to the record.

RECURRENCE

Donald O. Cundiff, Docket No. 99-2370, Issued October 16, 2000

The issue in this case was whether the claimant had met his burden of proof in establishing that he sustained a recurrence of disability causally related to his employment injury.

The Office accepted that the claimant acquired pleural thickening as a result of his twenty-seven years of federal employment as an asbestos worker and insulator. He was last exposed in 1987 when he resigned his position with the employing agency. Effective January 1988, the claimant was elected as business manager of an asbestos union and performed administrative duties for approximately nine years until he lost an election for another term in January 1997.

The claimant alleged a recurrence of disability effective January 1997, and filed a claim for continuing compensation due to his accepted condition. He submitted medical reports indicating that he could work, with restrictions against strenuous physical exertion, exposure to temperature extremes, airborne particles, fumes or fibrosing agents such as asbestos.

The Office denied the claimant's request for compensation for lost wages as the evidence of record did not support disability from work. The claimant requested an oral hearing where his representative argued that, if the claimant had not had a breathing impairment, he would have been able to go back to work for the employing establishment for a couple of years before retirement after he lost the election with the union. He argued that the claimant filed a claim for lost wages because he could not go back to work for the employing agency. The hearing representative affirmed the Office's decision denying compensation for lost wages.

The Board noted that the issue in this case was medical in nature. The claimant must establish that he was totally disabled as of January 1997 due to his accepted medical condition. The medical evidence of record indicated that the claimant could not perform exertional duties and outlined the claimant's previously evaluated restrictions when he worked for the employing agency.

The Board further noted that the claimant's work duties were restricted while at the employing agency due to his lung condition. However, there was no evidence that he resigned from this position because he was incapable of performing his assigned duties due to the accepted employment injury. Moreover, there was no evidence that the claimant was medically incapable of performing his assigned duties as a business manager with the union at any time during his tenure, or incapable of work after he left employment on January 1, 1997, due to his employment related condition. The Office's decision was affirmed.

TIME LIMITATION - OCCUPATIONAL DISEASE

Duet Brinson, Docket No. 00-94, Issued December 13, 2000

The issue in this case was whether the claim for an occupational disease was barred by the applicable time limitation provisions of the Federal Employees' Compensation Act.

In this case, the claimant filed a claim for compensation on August 21, 1997 alleging that on February 8, 1985 he became aware that he had developed a skin condition caused or aggravated by his exposure to PCB in his federal employment. The case file contained evidence that the claimant's last exposure to PCB was prior to 1994 when he was placed in a light duty position with the employing agency where exposure would be nonexistent. Since the claimant did not file his claim for compensation until August 21, 1997, he was clearly outside the three-year time limitation period and his claim was therefore untimely.

However, the Board further noted that "appellant's claim would still be regarded as timely under section 8122(a)(1) of the Act if his immediate supervisor had actual knowledge of his alleged employment-related injury within 30 days. The knowledge must be such as to put the immediate superior reasonably on notice of appellant's injury. An employee must show not only that his immediate superior knew that he was injured, but also knew or reasonably should have known that it was an on-the-job injury. In the instant case, appellant's supervisor, Mr. Bakke submitted an April 29, 1994 statement indicating that he had knowledge of appellant's exposure to PCB throughout late 1984 and issued him a dispensary note by February 1985 for appellant to confirm exposure to PCB. The Board notes that Mr. Bakke's statement establishes that appellant's immediate supervisor had actual knowledge of injury. Consequently, the exception to the statute is met, and appellant's claim for compensation is timely."

WAGE-EARNING CAPACITY - ACTUAL EARNINGS

Redrick T. Hobby, Docket No. 98-1826, Issued October 13, 2000

The notable issue in this case was whether the Office properly determined the claimant's loss of wage-earning capacity.

In this instance, the Office accepted that a traumatic injury of June 23, 1993 resulted in contusions of the neck, back and right ankle and a herniated nucleus pulposus at C5-6.

In August 1997, through vocational rehabilitation intervention, the claimant completed a course of studies that qualified him to work as a paralegal. On October 20, 1997, he began work as a paralegal for a law firm with wages of $280.00 per week. By decision dated November 10, 1997, the Office noted that the claimant had been re-employed as a paralegal effective October 20, 1997, and advised him that his compensation benefits would be reduced based upon his capacity to earn wages of $280.00 per week.

The Board reversed this decision finding that the claimant had been employed in this position for only 20 days when the Office made the wage-earning capacity determination.

The Board noted that wage-earning capacity is the measure of the employee's ability to earn wages in the open labor market under normal employment conditions. Generally, wages actually earned are the best measure of wage-earning capacity and, in the absence of evidence showing that they do not fairly and reasonably represent the injured employee's capacity, they must be accepted as such measure. Office procedures provide that a determination regarding whether actual earnings fairly and reasonably represent wage-earning capacity will be made after an employee has been working in a given position for more than 60 days.

Consequently, while it is appropriate to reduce a claimant's compensation benefits immediately upon his receipt of wages, the determination of whether those wages represent his wage earning capacity cannot be made until the employee has worked in that capacity for at least 60 days.

WAGE-EARNING CAPACITY - MEDICAL EVIDENCE

Douglas W. Lenton, Docket No. 99-899, Issued December 15, 2000

The issue in this case was whether the Office met its burden of proof to establish that the position of hotel clerk represented the claimant's wage-earning capacity.

Vocational rehabilitation efforts were not successful and the Office proceeded to determine the claimant's wage-earning capacity in a selected position. By decision dated October 16, 1998, the Office found that the position of hotel clerk represented the claimant's wage-earning capacity and reduced compensation payments accordingly. In this decision, the Office granted the weight of the medical evidence to a referee medical specialist's reports from 1991 and 1992. The Office also noted that an October 5, 1995 work restriction evaluation by the claimant's treating physician supported the physical limitations and work restrictions found by the referee medical specialist.

Prior to the Office's October 16, 1998 decision, the claimant's attorney submitted medical reports from the claimant's treating physician dated April 15, 1997 and September 14, 1998 that supported total disability causally related to the accepted employment injury.

The Board reversed the Office's decision and benefits were reinstated retroactively. The Board noted that the referee specialist's reports were over six years old at the time of the Office's determination and the 1995 report from the treating physician was over 3 years old. These reports were, therefore, of limited probative value in determining the claimant's wage-earning capacity as of October 16, 1998. The Board held that the Office cannot modify compensation benefits without first obtaining a detailed current description of the claimant's disability and ability to perform work.

FECA CIRCULAR NO. 02-04 **December 2001**

SUBJECT: SELECTED ECAB DECISIONS FOR JANUARY - MARCH, 2001

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

The subjects addressed include: attendant's allowance; compensation – basic/augmented compensation – dependents; emotional conditions – performance of duty – administrative/personnel actions – error or abuse; mailbox rule; medical opinions – clarification of second opinion report; medical examination – obstruction or refusal to undergo; medical expenses and treatment – statutory provision; medical expenses and treatment – termination of; medical opinions – conflict in medical opinion; overpayments – amount; performance of duty – consequential injuries; performance of duty – premises doctrine; reconsideration under section 8128 – basis for merit review; reconsideration under section 8128 – one year time limitation; schedule award – factors in calculating impairment; termination of compensation – abandonment of suitable work; termination of compensation – refusal of suitable work; wage-earning capacity – actual earnings.

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)

ATTENDANT'S ALLOWANCE

Michael W. Dombrowski, Docket No. 99-200, Issued January 12, 2001

The issue in this case was whether the Office properly determined the claimant's entitlement to an attendant's allowance. The Board upheld the Office's decision to approve fewer hours necessary for an attendant than requested by the claimant.

"Under this provision, the Office may pay an attendant's allowance upon finding that a claimant is so helpless that he or she is in need of constant care. A claimant is not required to need around-the-clock care, but only has to have a continually recurring need for assistance in

personal matters. An attendant's allowance, however, is not intended to pay an attendant for performing domestic and housekeeping chores such as cooking, cleaning, doing the laundry or providing transportation services. It is intended to pay an attendant for assisting the claimant in personal needs, such as dressing, bathing or using the toilet. In requesting an attendant's allowance, the claimant bears the burden of proof in establishing by competent medical evidence that he or she needs attendant care within the meaning of the Act. An attendant's allowance is not granted simply upon request of a disabled employee or upon request of the employee's physicians. The need for attendant care must be established through rationalized medical opinion evidence. The Office, in turn, may pay up to $1,500.00 a month for full-time services, but it is not required to pay the maximum amount if not found to be necessary and reasonable for an attendant's services.

In this case, appellant sustained injury to his right shoulder on April 28, 1993 resulting in a dislocation and multiple surgeries and resections of the right shoulder joint. To support his request for an attendant's allowance, appellant provided a statement in which he estimated the amount of time required for care from individuals, including his daughters and ex-wife, to consist of approximately six hours a day. The Board notes that the Office specifically requested that Dr. Paxon, appellant's attending physician, review his medical records and comment regarding the necessity of an attendant's allowance; if determined to be necessary, the date an attendant was first required; and the hours of daily care required. Dr. Paxon was requested to comment on the hours of estimated attendant care listed by appellant.

In a report of July 16, 1997, Dr. Paxon noted his concurrence that attendant care was necessary for residuals of appellant's right shoulder condition, providing a review of the surgical procedures performed. However, he was not fully responsive to the Office's request as to the number of hours required for attendant care and how such care pertained to the accepted right shoulder condition. Dr. Paxon noted that appellant had listed long bathing times, but noted that such was due to a nonemployment-related perspiration dysfunction and to a 'plethora' of other orthopedic conditions besides those pertaining to the accepted right shoulder employment injury for which appellant soaked in heated water. He acknowledged that the six hours per day appellant provided in listed daily activities appeared excessive but did not provide any independent assessment or estimate of the time required for necessary attendant care to assist in dressing, bathing or using the toilet.

The Board finds, after review of appellant's statement and the medical evidence of record, that the Office properly allowed four hours a day of attendant care from April 23, 1993 to April 7, 1997 for 136 hours. As the Office is only required to pay an attendant as much as it finds reasonable and necessary, the Office did not err in authorizing the attendant's allowance for two hours of bathing, one hour for feeding, and one-half hour respectively for dressing and using the toilet. Appellant has failed to submit any evidence to establish that he is entitled to a greater attendant's allowance than that he has received."

COMPENSATION - BASIC/AUGMENTED COMPENSATION - DEPENDENTS

Lois Masengale, Docket No. 99-1206, Issued February 22, 2001

The issue in this case involved an overpayment of compensation based on the Office's determination that a child over age 18 was not in full-time student status.

The Board reversed the Office's decision and provided the following discussion of student status:

"Section 8133(b) (of the Federal Employees' Compensation Act) provides in pertinent part that the compensation payable under subsection (a) is paid from the time of death until a child dies, marries or becomes 18 years of age. Notwithstanding, compensation that would otherwise end because the child has reached 18 years of age shall continue if he is a student as defined by section 8101 for as long as he continues to be a student, up until age 23 or he marries.

Section 8101(17) provides that student means an individual under 23 years of age who has not completed four years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an accredited institution...

Section 10.5(a)(25) of the Code of Federal Regulations, defining 'student' states: 'An individual continues to be a student during any interim between school years if the interim does not exceed four months and the individual shows to the satisfaction of the Office that he or she has a bona fide intention of continuing to pursue a full-time course of education or training during the semester or other enrollment period immediately after the interim, or during periods of reasonable duration during which, in the judgement of the Office, the individual is prevented by factors beyond his or her control from pursuing his or her education.'

The Federal (FECA) Procedure Manual states: 'Where a student is prevented by reasons beyond his or her control (such as a brief but serious illness) from continuing in school, compensation may be continued for a period of reasonable duration. However, any such period would be counted toward the four years of entitlement. The claims examiner will determine what constitutes 'reason beyond the control' of the beneficiary and decide what may be considered a period of reasonable duration during which compensation may be continued. The claims examiner will also place a memorandum in the file outlining the circumstances of the case and the reasons for the decision.'

The record establishes that throughout the overpayment period, Larry provided no indication that he did not want to pursue his education. Larry never dropped a course because he decided that he did not want to attend school. Rather, when appellant suggested that Larry take a semester off, he said he did not want to give up. In addition, appellant testified that there was not a time since August 1994 that Larry did not attend summer school.

Larry switched from full-time to half-time status on several occasions because he was unable to

manage his courseload due to his learning disability, depression and alcoholism. His difficulties are well documented in the record. Also, he was advised by Washington State University to drop courses so he would not fail. Up until March 1996, when Larry experienced alcoholism, two of the three half-time periods, November 18 through December 23, 1994 and April 14 through May 12, 1995, lasted only one month, and the other period October 27 through December 22, 1995, lasted almost two months. During the overpayment period the record establishes that there was not a period of four months when Larry did not attend school.

Contrary to the hearing representative's finding that Larry's conditions were chronic according to Dr. Hones, a licensed psychologist, Larry overcame his emotional and learning disability condition in high school and achieved high grades until his father's death.

Based on the factual circumstances of this case, the Board finds that Larry was prevented from factors beyond his control from keeping up with a full course load, but was going to school as full time as he could manage up through June 30, 1997. Moreover, the record establishes a bona fide intent on his part to pursue his education full time. Inasmuch as the evidence of record establishes that Larry was a student under the Act from November 19, 1994 through June 30, 1997, the Board finds that the Office improperly determined that appellant received an overpayment in the amount of $7,876.99 during this period."

EMOTIONAL CONDITIONS - PERFORMANCE OF DUTY - ADMINISTRATIVE/PERSONNEL ACTIONS - ERROR OR ABUSE

Jacqueline E. Brown, Docket No. 99-1720, Issued January 29, 2001

The issue in this case was whether the claimant sustained an emotional condition in the performance of duty. The interesting discussion involves erroneous administrative or personnel actions taken by the employing agency where there was no intentional wrongdoing.

The Board stated: "Most of the employment incidents and conditions to which appellant attributes her emotional condition concern administrative or personnel actions by the employing establishment. Appellant's primary contention is that she experienced stress due to the employing establishment's 'tampering' with her paychecks. The employing establishment acknowledged that it paid appellant incorrectly following a December 1, 1993 settlement agreement that afforded appellant pay retention effective May 30, 1993, and that the error in her retained pay was not corrected until June 1997. In her February 11, 1999 decision, an Office hearing representative found that the mistakes and miscalculations in appellant's back pay were not compensable because they were not intentional. However, intentional wrongdoing is not required under the Act; an error from a misunderstanding at the employing establishment may be compensable. Appellant has established that the employing establishment erred by paying her at the wrong rate and also in sending her letters in February 1998 erroneously indicating that certain amounts would be deducted from her salary to pay for appellant's health benefits during her period of leave without pay from June 1997 to January 1998."

Although the Board found that the claimant had established compensable factors of employment, the Office's decision was modified but affirmed as the medical evidence was insufficient.

MAILBOX RULE

Ethel Walker-Anderson, Docket No. 99-1284, Issued March 15, 2001

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

The Office accepted a work related medical condition of mild, chronic, low back strain. By decision dated May 13, 1996, the Office found that the evidence failed to demonstrate that the claimant's current condition was causally related to her August 3, 1984 work injury. The claimant requested reconsideration and, by decision dated November 25, 1996, the Office denied modification of its prior decision.

By letter dated November 24, 1998, the claimant, through her authorized union representative, requested reconsideration, stating that a previous request for reconsideration dated November 24, 1997 had been mailed to the Office but no response had been received. The claimant also submitted a copy of the November 24, 1997 letter.

By decision dated December 23, 1998, the Office found the claimant's request for reconsideration was not timely filed within the one-year limit and that it did not present clear evidence of error. The Office noted that the November 24, 1997 request did not appear in the case file but the request had been reviewed and noted that no new evidence was submitted with this request for reconsideration.

The Board found that the request was timely filed noting that "While the original of appellant's representative's November 24, 1997 request for reconsideration does not appear in the case record, the copy submitted with the November 24, 1998 letter reflects a proper address and mailing in the ordinary course of business. The copy of the November 24, 1997 letter is on the letterhead of a business organization, the National Association of Letter Carriers, that has a mailing custom or practice. Through the application of the 'mailbox rule' this creates a presumption that the Office received the November 24, 1997 request for reconsideration. Corroborating the existence and mailing of the November 24, 1997 request for reconsideration are medical reports dated January 10, February 24 and October 24, 1997, all of which are date-stamped as received by the Office on November 25, 1997."

MEDICAL EXAMINATION - OBSTRUCTION OR REFUSAL TO UNDERGO

Judy R. Tomlin, Docket No. 99-759, Issued February 15, 2001

This decision contains an interesting discussion of obstruction of a medical examination.

The Office initially accepted that the claimant sustained a temporary aggravation of adjustment and dysthymic disorder as a result of factors of her employment. By decision dated November 14, 1995, the Office determined that the temporary aggravation had ceased.

Subsequently, the Office advised the claimant that, based upon submission of additional medical evidence, a conflict existed in the medical opinion evidence between the claimant's treating physician and a second opinion physician. The claimant advised that she could not see "another strange" doctor and would not attend any future examinations by the second opinion physician. The Office, therefore, denied modification following a merit review of the record.

The claimant again requested reconsideration. The Office notified the claimant that she was scheduled for a medical appointment with a Board-certified psychiatrist and that the impartial medical evaluation was required to resolve a conflict in the medical opinion evidence.

The claimant indicated that her illness precluded her from seeing any new physicians stating: "I am not refusing the examination, rather my mental limitation precludes me from going...I get severe emotional reactions even thinking about doing these things."

After providing appropriate notification of proposed suspension of compensation and consideration of additional medical evidence submitted, the Office found that the claimant had obstructed the impartial medical examination and had failed to establish good cause for refusing to undergo the medical evaluation. The Office further determined that the evidence of record was in conflict and therefore insufficient to modify the Office decision that the accepted temporary aggravation had ceased.

The Board found that the Office properly suspended the claimant's eligibility to compensation on the grounds that she obstructed a medical examination. The Board noted that the claimant submitted a report from her attending physician that stated she was precluded from attending any further medical evaluations scheduled by the Office. The Office medical adviser reviewed this report and opined that the attending physician's "conclusion was unreasonable and reinforced the need for another opinion from a psychiatrist".

The Board concluded: "Because appellant's refusal to attend an impartial medical evaluation appears from the record to result from her own subjective fears and there is no reasoned medical opinion to establish that such an evaluation would aggravate appellant's emotional condition, the Board concludes that appellant has not shown good cause for her refusal to attend an impartial medical evaluation."

In addition, the Board found that the Office properly denied modification of the prior decision for the reason that, until the claimant "undergoes an impartial medical evaluation, the medical evidence remains insufficient to warrant modification of her claim to reflect that she was disabled from a work-related condition on or after October 25, 1994".

MEDICAL EXAMINATION - OBSTRUCTION OR REFUSAL TO UNDERGO

Lula Jones, Docket No. 00-1472, Issued March 27, 2001

The issue in this case was whether the Office properly determined that the claimant's request for reconsideration was untimely filed. However, the interesting discussion centered on the Office's suspension of compensation benefits due to obstruction of a medical examination.

The Office accepted that the claimant developed right DeQuervain's tenosynovitis due to factors of her federal employment. The employing agency subsequently offered the claimant a modified job that she accepted on August 12, 1998.

The Office notified the claimant that she had been scheduled for a functional capacity evaluation to determine the extent and degree of her remaining disability. The claimant declined to submit to the functional capacity evaluation. After appropriate development and notification, the Office suspended her compensation effective September 24, 1998, because she obstructed a medical examination.

By letter dated September 8, 1999, the claimant requested reconsideration, stated that she would comply with further requests and asked that her compensation be reinstated as soon as possible. The Office determined that, "although the word reconsideration was used in appellant's September 8, 1999 letter, appellant had actually indicated her willingness to cooperate and requested reinstatement. The claims examiner determined therefore that a new medical evaluation should be scheduled and the case should not be assigned as a 'reconsideration'."

The Office then rescheduled the claimant for a functional capacity evaluation on October 25, 1999, and advised her of the consequences of failing to cooperate or refusing to submit to the evaluation.

The claimant appeared for the functional capacity evaluation on October 25, 1999. The rehabilitation counselor indicated that, "appellant's scores taken from pain questionnaires were compared to observed behavior and movement patterns during the evaluation tasks and it was determined that her perception of pain and disability was disproportionate to impairment. It was also determined that appellant exhibited signs of exaggeration and that the test results were invalid, which indicated that appellant gave a submaximal effort throughout the entire evaluation."

By letter dated November 18, 1999, the Office advised the claimant that the September 24, 1999 decision suspending compensation remained in effect since she did not fully cooperate with the October 25, 1999 evaluation. By letter dated December 2, 1999, the claimant requested reconsideration of the November 18, 1999 letter. By decision dated December 23, 1999, the Office denied the request for reconsideration on the basis that it was not timely filed, explaining that the November 18, 1999 letter was not a decision but an explanation that the September 24,

1998 decision remained in effect. The claimant's right to reconsideration had, therefore, expired one year from the September 24, 1998 decision.

The Board remanded the case stating:

"The record indicates that the Office's September 24, 1998 decision properly suspended appellant's compensation, effective July 24, 1994, as she had refused to appear at a medical examination ordered pursuant to section 8123. The Board finds, however, that in its December 23, 1999 decision, the Office improperly determined the matter of her compensation through the appeal process of a reconsideration and not on the issue regarding her suspension of compensation.

Appellant indicated in her September 8, 1999 request letter that she was willing to cooperate with future requests and asked that her benefits be reinstated as soon as possible. Pursuant to 20 C.F.R. § 10.323, there is no time limit on a claimant expressing a willingness to comply. Following an October 25, 1999 evaluation which indicated that she failed to fully cooperate with testing, the Office notified her that its prior decision dated September 24, 1998 remained in effect and did not issue a separate suspension decision that would afford appellant new appeal rights. In its December 23, 1999 decision, the Office did not determine whether appellant's compensation should be reinstated but that appellant's December 2, 1999 reconsideration request was untimely with respect to the September 24, 1998 decision. The Board therefore vacates the Office's December 23, 1999 decision and remands the case for the Office to properly address the issue of whether appellant's compensation should be reinstated pursuant to her September 8, 1999 requests, pursuant to 20 C.F.R. § 10.323."

MEDICAL EXPENSES AND TREATMENT - STATUTORY PROVISION

William C. Chase, III, Docket No. 99-865, Issued January 4, 2001

This decision contains an interesting discussion by the Board of section 8103 of the Federal Employees' Compensation Act. The issue before the Board was whether the Office met its burden of proof in terminating authorization for chiropractic treatment after January 8, 1996 for an accepted back injury of January 12, 1988.

The Board's discussion is as follows:

"Section 8103(3) of the Federal Employee's (sic) Act, defining services and supplies, states: 'Reimbursable chiropractic services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist, and subject to regulation by the Secretary.' The diagnosis of subluxation must, however, also be established as employment related for chiropractic treatment to be reimbursable.

In this case, the Office relied on the failure of chiropractic treatment to cure, provide relief, reduce the degree or period of disability, or aid in lessening the amount of compensation to terminate chiropractic benefits.

Under section 8103 of the Act, the Office has the authority to provide medical services, appliances and supplies to an employee injured while in the performance of duty which the Office considers likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. In interpreting section 8103, the Board has recognized that the Office has broad discretion in approving services provided under the Act.

The Office has the general objective of ensuring that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time. The Office, therefore, has broad administrative discretion in choosing the means to achieve this goal. The only limitation on the Office's authority is that of reasonableness. Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probably (sic) deductions from know (sic) facts.

In its prior decision, the Board found that the Office failed to give adequate notice to appellant of its proposal to terminate chiropractic treatment under section 8103. The evidence has not changed since the Board made this determination. There is still no indication in the medical evidence that the continuing chiropractic treatment was furthering the objectives of section 8103. The only relevant evidence submitted was an opinion by Dr. Hepner (the Office's second opinion examiner) that appellant had little change in his symptoms and that there was nothing else he had to offer him. This opinion does not indicate that further chiropractic treatment would further the goals under section 8103."

The Office's decision was affirmed.

MEDICAL EXPENSES AND TREATMENT - TERMINATION OF

John C. Knecht, Docket No. 99-742, Issued January 17, 2001
Dorothy Reese, Docket No. 98-1412, Issued January 29, 2001

In both of these cases, the Board found that the Office failed to consider the termination of medical benefits and the termination of compensation as separate issues. The resolution of the issue of ongoing compensation does not necessarily resolve the issue of ongoing entitlement to medical benefits.

In the case of John Knecht, the Office terminated compensation for wage loss and medical benefits based on a second opinion examination. The Board upheld the termination of compensation for wage loss but reversed the termination of medical benefits. The Board noted that the Office terminated compensation and medical benefits by decision dated January 9, 1997. However, there was no indication that a pre-termination notice for on-going medical benefits was sent to the claimant prior to termination. The Board, therefore, upheld the Office's termination of compensation but reversed the Office's termination of medical benefits.

In the case of Dorothy Reese, the Office finalized a proposed termination of compensation by decision dated January 23, 1997 finding that the well-rationalized report of the impartial medical examiner was entitled to special weight and, therefore, constituted the weight of the medical opinion evidence. The Board upheld the Office's termination of compensation finding that the impartial medical opinion was sufficiently well rationalized and based on a proper factual and medical background to entitle the report to special weight. However, the Board reversed the Office's termination of medical benefits stating: "Because Dr. Wert's impartial medical report did not address whether appellant had any nondisabling residuals of her accepted employment-related conditions, it does not constitute the weight of the medical opinion evidence on this issue and a conflict remains unresolved."

MEDICAL OPINIONS - CLARIFICATION OF SECOND OPINION REPORT

Jessie M. Littleford, Docket No. 00-675, Issued March 7, 2001
Tamarra E. Espeut, Docket No. 99-672, Issued March 15, 2001
Richard F. Bequette, Docket No. 00-1145, Issued March 8, 2001

In the Jessie M. Littleford case, the Office directed the claimant to undergo a second opinion examination to clarify whether her claimed condition of toxic polyneuropathy was causally related to exposure to various solvents and chemicals during her federal employment. The second opinion physician requested authorization to perform a number of tests to rule out organic cause for the claimant's medical condition. The Office authorized these tests but stated that the second opinion physician had 30 days to submit his test results. When the results were not forthcoming in 30 days, the Office denied the claim.

In the Tamarra Espeut case, the Office referred the claim to its medical advisor for an opinion as to the appropriateness of a recommended right knee surgical procedure. The medical advisor noted that the indications for surgery were unclear and recommended a second opinion surgical consultation to obtain a proper diagnosis of the claimant's right knee condition and to ascertain whether surgery was required. The Office did not refer the claimant for further medical evaluation as recommended but instead denied authorization of the recommended surgical procedure.

In the Richard Bequette case, the Office referred a medical report to its medical advisor for a determination on the percentage of permanent impairment based on the A.M.A. Guides, 4th edition. The medical advisor's calculations were then forwarded to the claimant's attending physician for concurrence. The attending physician indicated that the calculations did not consider the claimant's pain or weakness. The Office medical advisor, when asked why these were not included, indicated that the attending physician did not provide information for specific weakness, atrophy or nerve impairment. He suggested that the Office should send the attending physician the appropriate pages of the A.M.A. Guides to document the permanent partial impairment for muscle and nerve impairment. The Office did not pursue its medical advisor's recommendation but paid a schedule award based on the medical advisor's initial calculations.

In all three cases the Board remanded the claim for additional medical development noting that: "Once the Office undertakes to develop the medical evidence, it has the responsibility to do so in a proper manner". If the Office requests a medical opinion from a medical advisor, SECOP or referee, it has the obligation to follow through on the physician's recommendations or provide an explanation of why those recommendations were not followed.

MEDICAL OPINIONS - CONFLICT IN MEDICAL OPINION

Johnny L. Sammons, Docket No. 00-524, Issued January 5, 2001

The issue in this case was whether the Office properly terminated the claimant's compensation. However, the issue hinges on whether the second opinion examiner's report was sufficient to establish a conflict in medical opinion.

The Board's discussion is as follows:

"The Office referred appellant to Dr. Thomas Whitesides, a Board-certified orthopedic surgeon, for an examination and second opinion. In an October 14, 1997 report, Dr. Whitesides indicated that appellant had low thoracic pain and tenderness to palpation. In a November 25, 1997 report, Dr. Whitesides reported that a second CT scan and a bone scan were within normal limits, showing no lesions or fracture. An Office claims examiner, in a January 28, 1998 letter, asked whether appellant had any objective evidence of disability and whether the strain appellant had sustained on January 8, 1997 had resolved. In a February 2, 1998 memorandum, the claims examiner noted that Dr. Whitesides had called her in reference to the January 28, 1998 letter. He indicated that he had been unaware that the Office had requested a second opinion from him regarding appellant, noting that he apparently had not received the Office's letter requesting such an examination. The claims examiner reported that Dr. Whitesides stated appellant only had subjective complaints of pain with no objective evidence of disability. She related that the doctor indicated that appellant had no objective evidence to show any residuals from the strain he had sustained a year previously. The Office subsequently received a copy of the January 28, 1998 letter from Dr. Whitesides who answered 'no' to the question of whether appellant had any objective evidence of disability and 'probably' to the question of whether the strain appellant had sustained had resolved."

The Office determined that a conflict of medical opinion existed between the claimant's attending physician and Dr. Whitesides. The claimant was, therefore, referred for an impartial medical examination.

The Board reversed the Office's decision to terminate compensation stating: "The Office's decision was based on the conclusion that the report of Dr. James, acting as an impartial medical specialist, resolved a conflict in the medical evidence between Drs. Whitesides and Earls. A review of the record, however, shows that Dr. Whitesides' written report on the issues of whether appellant had any objective evidence of disability and whether the effects of the employment injury had resolved consisted of one word answers on a copy of the letter sent to him by the Office. The only report of Dr. Whitesides' rationale for his opinion was cited in a memorandum of a telephone conversation he had with an Office claims examiner. A report of an oral conversation of medical rationale is not sufficiently reliable to find that the written report of this case was adequate to cause a conflict in the medical evidence. Such a medical report, with rationale, must be in writing before it can be considered as probative, reliable medical evidence. The description of Dr. Whitesides' oral report, therefore, was insufficient to cause a conflict in the medical evidence. As a result, Dr. James cannot be considered an impartial medical specialist."

OVERPAYMENTS - AMOUNT

Jessie M. Banks, Docket No. 00-481, Issued March 16, 2001

The issue of interest before the Board in this case was whether the Office properly determined that the claimant received an overpayment of compensation in the amount of $4,996.40.

The Office accepted lumbosacral and cervical sprains and a contusion of the left thigh as resulting from a work-related incident on April 26, 1995.

By decision dated September 17, 1998, the Office terminated compensation benefits as the weight of the medical evidence failed to show ongoing residuals of the accepted work injury. However, compensation benefits were not terminated as of the date of the decision.

By decision dated February 3, 1999, the Office found that the claimant had been overpaid benefits in the amount of $6,718.44. The overpayment occurred because the claimant's compensation was terminated by decision dated September 17, 1998 but benefit checks continued through January 1, 1999. The Office further found that the claimant was not without fault in the creation of the overpayment. By decision dated April 7, 1999, the Office finalized its preliminary overpayment decision.

The claimant requested reconsideration of the overpayment decision, arguing that she had actually returned to work on September 28, 1998 and not September 17, 1998 and that she cashed only two of the four checks she received after the latter date. The Office agreed that one of the checks had been returned and adjusted the amount of the overpayment accordingly.

The Board found that the Office improperly determined that the claimant received an overpayment of compensation in the amount of $4,996.40 for the period September 17, 1998 to January 1, 1999.

The Board specifically noted that the claimant alleged that she did not cash two of the four benefit checks she received during the period in question. The Office determined that one of the four checks was returned. However, the record contains no evidence that the claimant cashed the check covering December 6, 1998 through January 1, 1999.

The case was remanded for further development to determine if the check in question was actually cashed prior to a determination of the amount of the overpayment.

PERFORMANCE OF DUTY - CONSEQUENTIAL INJURIES

Pamela G. Gilmore, Docket No. 00-318, Issued March 16, 2001

The issue in this case was whether the claimant sustained an injury while in the performance of duty.

The claimant filed a Notice of Traumatic Injury alleging that on February 18, 1997, she injured her right hip, buttock, shoulder and knee when she fell on a wet parking lot after stepping off the walkway from the Bainbridge Ferry Terminal. The claimant further alleged that, at the time of the February 18, 1997 injury, she was returning from a visit to her physician for treatment of her February 13, 1997 employment related injury. The employing agency confirmed that the claimant was receiving continuation of pay during this visit to her physician.

The Office initially denied the claim on the grounds that the evidence of record failed to establish that the claimant sustained an injury as a result of the incident on February 18, 1997.

Following an oral hearing, the Office's decision was affirmed but modified to reflect that the February 18, 1997 incident did not occur in the performance of duty.

The Board found that the February 18, 1997 incident did occur in the performance of duty. "The Board has held that when an employee suffers additional injuries because of an accident in the course of a journey to a doctor's office occasioned by a compensable injury, the additional injuries are generally held compensable. There are exceptions in cases where there is an added factor weakening the causal connection such as doubt about whether the trip was really authorized, when the purpose of the trip was not treatment but examination for purposes of meeting the employing establishment's requirement of a physical fitness certificate or when the original injury was not work related."

In this case, the evidence clearly indicated that the claimant was returning from a visit to her physician for treatment of an accepted work related injury. Consequently, the February 18, 1997 incident occurred in the performance of duty.

PERFORMANCE OF DUTY - PREMISES DOCTRINE

Eileen R. Gibbons, Docket No. 99-2517, Issued January 10, 2001

The issue in this case was whether the claimant was injured in the performance of duty when she slipped on wet pavement in the employing agency's parking lot.

The incident occurred during the claimant's morning break. She had experienced a flat tire on the way to work and had returned to the parking lot during her morning break to check the tire for appropriate size for a replacement tire. The claimant slipped and fell in the parking lot while she was engaged in this activity.

The Office denied the claim finding that the incident did not occur in the performance of duty.

The Board reversed the Office's decision, finding that the claimant had established that an injury occurred in the performance of duty.

"In the present case, appellant fell on the employing establishment premises while walking to her personal vehicle located on the employing establishment parking lot. Appellant's supervisor confirmed that the employing establishment controlled and owned the parking lot. At the time of her fall, appellant was on an authorized break, going to inspect the size of her tire so as to replace it after experiencing a flat on the way to work that morning. The evidence establishes that appellant was at a place she would be expected to be in connection with her employment, walking to her personal vehicle while on employing establishment property and thus the incident occurred at a place where appellant was reasonably expected to be as a result of her employment.

Further, appellant was engaged in an activity which may be characterized as reasonably incidental to the conditions of her employment. Although appellant's activity of inspecting the size of her tire from her personal vehicle was not required by the employing establishment, the Board finds that it can be characterized as an activity reasonably incidental to her employment. Appellant's action of walking to her personal vehicle, while on an authorized break, was connected to the work she was employed to perform because it is reasonable that appellant might leave the building on her break, to walk to her vehicle parked on employing establishment property. The record also indicated other employees apparently took smoking breaks in the same area where appellant fell and there is no evidence that employees were prohibited from this area during breaks. Therefore, appellant was engaged in an action incidental to the duties of her employment."

RECONSIDERATION UNDER SECTION 8128 - BASIS FOR MERIT REVIEW

Cheryl L. Bryant, Docket No. 00-781, Issued March 1, 2001

The issue before the Board in this case was whether the Office properly denied the claimant's request for reconsideration.

In September 1992, the claimant was injured in the performance of duty. The claim was accepted for the conditions of lumbar strain, contusion to the left hip and abrasions to both feet.

On June 16, 1996, the claimant filed a notice of recurrence, alleging that she had sustained a recurrence of disability on July 1, 1993 as a result of the September 2, 1992 employment injury. The Office denied this claim on the grounds that the evidence of record failed to demonstrate a causal relationship between the work incident of September 15, 1992 and the claimed recurrence.

Subsequent to a request for reconsideration, the Office performed a merit review of the file but denied modification of the prior decision. The Office noted that the claimant had sustained three automobile accidents and the medical opinions submitted to support the claim were of limited probative value because it was not known whether the physicians were privy to any medical records for prior injuries or were aware of all the intervening injuries.

The claimant again requested reconsideration of her claim in July 1999. In support of this request she submitted physical therapy records, treatment records and medical notes from 1993, as well as treatment records from June 17, 1991. In October 1999, the Office denied the claimant's request for reconsideration without reviewing the merits of her claim. The Office found that the claimant presented no argument for error and that the evidence was not relevant to the employment injury of September 2, 1992.

The Board upheld this decision noting: "In its July 17, 1998 decision on the merits of appellant's claim, the Office explained that the medical opinion evidence was deficient because it was not known whether the physicians who rendered the opinions were knowledgeable about appellant's other injuries. The point was that medical records relating to these other injuries should be made available to the opining physicians so that they may base their opinions on a sufficiently complete and accurate factual and medical background. It is the opinion of these physicians, not the background records themselves, that is relevant to the issue of causal relationship."

RECONSIDERATION UNDER SECTION 8128 - ONE YEAR TIME LIMITATION

Ellis Hadnot, Docket No. 99-1495, Issued February 16, 2001
Darrell Stovall, Docket No. 99-2562, Issued March 14, 2001
Howard Y. Miyashiro, Docket No. 01-313, Issued March 19, 2001

The issue in all of these cases centers on the Office's handling of reconsideration requests particularly with respect to determining whether the request was timely filed.

In the case of Ellis Hadnot, the hearing representative's decision was dated November 26, 1997 and was accompanied by a cover letter dated December 1, 1997. By letter dated December 2, 1998 (but date-stamped as received by the Office on December 1, 1998) the claimant requested reconsideration. The request was denied as not timely filed. The Board remanded the case for consideration of a timely filed request for reconsideration, noting: "Where an Office hearing representative prepares his decision on one date, which appears on the decision, but does not mail it to appellant until a later date appearing on a cover letter accompanying the decision, the date of issuance, for purposes of computing when time begins to run to file a request for reconsideration, will be considered the date of mailing. This is consistent with the Office's regulation in place at the time of the Office's December 7, 1998 decision, which stated that the Office hearing representative 'shall terminate the hearing by mailing a copy of the decision, setting forth the basis therefor, to the claimant's last known address and to the claimant's representative, if any'. It is also consistent with Board decisions finding that an Office decision was not properly issued where it was sent to an incorrect address or where the decision was not sent to the claimant's authorized representative."

In the case of Darrell Stovall, the claimant filed a CA-2a dated January 19, 1999 on which he indicated that he was submitting new medical evidence and requested that the Office "please look at" this new evidence and
"reopen" his case. On June 25, 1999, the claimant submitted a reconsideration request and resubmitted some of the new medical evidence. The Office denied the June 25, 1999 reconsideration request as not timely filed. The Board remanded the case stating: "The Board has held that a request for reconsideration need not be on any particular form but must be in writing, identify the decision and the specific issue or issues for which reconsideration is being requested and be accompanied by relevant and pertinent new evidence or argument not previously considered. Appellant's submission of the January 19, 1999 recurrence claim form in which he indicated that he sought request for reconsideration of the Office's decision and was submitting new evidence in support of his request is sufficient to constitute a valid request for reconsideration."

In the case of Howard Miyashiro, on October 23, 2000 he filed an application for review of an August 1, 2000 non-merit review decision. This request was denied on the grounds that the request had not been filed within one year of Office merit decisions dated March 25, 1996 and

January 16, 1997 and did not establish clear evidence of error. On January 11, 2001, the Director of the Office filed a motion to remand the case. "The Director advised that, as the Board issued a merit decision on December 23, 1999, appellant's request for reconsideration received by the Office on July 26, 2000 had been timely filed and, therefore, the August 1, 2000 decision of the Office was incorrect." The Board concurred with the Director's request and the case was remanded. While decisions issued by the Board are not subject to review by the Office, a right to reconsideration within one year accompanies any merit decision on the issues. This includes any hearing or review of the written record decision, any denial of modification following a reconsideration, any merit decision by the Employees' Compensation Appeals Board (ECAB) and any merit decision following action by the ECAB.

SCHEDULE AWARD - FACTORS IN CALCULATING IMPAIRMENT

John T. Hanoumis, Docket No. 00-1205, Issued March 13, 2001

The issue is whether the claimant is entitled to more than 100% loss of his left fourth finger.

The Office accepted the claim for fracture of the left "pinky" finger (with subsequent hardware removal) and amputation of the left fourth finger.

Subsequent to appropriate development, the Office determined that the claimant had sustained a 100% loss of the left fourth finger and issued an award based on that finding.

The Board found that the case was not in posture for a decision. The Board noted that: "When the residuals of an injury to a member of the body specified in the schedule award provisions of the Act extend into an adjoining area of a member also enumerated in the schedule, such as an injury of a finger into the hand, of a hand into the arm or of a foot into the leg, the schedule award should be made on the basis of the percentage loss of use of the larger member."

In this case, the Board found that the medical evidence of record noted not only the 100% loss of use of the left fourth finger but also diminished grip strength of the left hand. The case was, therefore, remanded for further development to determine whether the left fourth finger impairment extended into the left hand.

TERMINATION OF COMPENSATION - ABANDONMENT OF SUITABLE WORK

Ronald D. Blackburn, Docket No. 00-540, Issued March 9, 2001

The issue before the Board in this case was whether the Office properly denied the claimant's request for vocational rehabilitation services. However, the interesting discussion hinged on whether the Office properly invoked section 8106(c)(2), finding that the claimant had abandoned suitable work.

The claim was accepted for a right wrist carpal scaphoid fracture with delayed union. In January 1997, the claimant was released by his treating physician to return to light duty work. The employing agency provided a light duty assignment within those restrictions and the claimant returned to work in January 1997.

Effective August 1, 1997, the claimant was removed from the employing agency for cause. He had a series of unauthorized absences, had attempted to falsify time and attendance records and failed to follow procedures for requesting leave.

In July 1998, the Office awarded the claimant a schedule award for 18% permanent impairment of the right upper extremity. Following the end of the schedule award, the Office undertook development to determine whether the claimant was entitled to vocational rehabilitation services.

By decision dated July 12, 1999, the Office denied vocational rehabilitation services on the grounds that the claimant had abandoned suitable work and, thus, forfeited all future entitlement to compensation.

The Board found that the Office did not appropriately invoke the penalty provisions of section 8106(c). The Board noted that: "The threshold issue is whether appellant did in fact abandon suitable work...To establish that appellant has refused or abandoned suitable work, the Office must first substantiate that the position offered was consistent with appellant's physical limitations, provide notice to the claimant of the penalty provision under section 8106(c)(2) and give the claimant a reasonable period to accept or reject the position or submit evidence or reasons why the position is not suitable and determine whether the reasons for declining or refusing the position were justified."

In this case, the Board found that the Office failed to give notice that the position he began performing in January 1997 was considered suitable work, or of the penalties for refusing or abandoning such employment. Therefore, "appellant cannot be found to have 'constructively' abandoned suitable work".

The Board, however, upheld the Office's decision to deny vocational rehabilitation services. It was noted that the Office exercised its discretion and denied the claimant's request for vocational rehabilitation services based upon an accurate reading of the facts of the case. "The Board finds

that this exercise of discretion stands independently of the Office's erroneous invocation of section 8106(c) standards, which thus constitutes harmless error on the issue of denial of vocational rehabilitation services."

TERMINATION OF COMPENSATION - REFUSAL OF SUITABLE WORK

Ronald J. Harper, Docket No. 99-1875, Issued March 27, 2001

The issue is whether the Office properly terminated the claimant's compensation benefits for refusal to accept a suitable job offer.

The Office accepted a claim for left knee sprain and authorized partial lateral meniscectomy surgery on March 17, 1997.

On June 1, 1997, the claimant's attending orthopedic surgeon approved a limited-duty job offer provided by the employing agency. On June 10, 1997, the claimant rejected the job offer based on his attending psychiatrist's orders that he could not work at the employing agency.

On June 19, 1997, the Office found the limited-duty position to be suitable, informed him of the penalty provisions of 5 U.S.C. § 8106(c) and allowed him 30 days to accept the position or offer his reasons for refusal.

The claimant, through counsel, contended that he was unable to perform the offered limited-duty position due to his emotional condition, which rendered him totally disabled, and his knee injury that prevented him from performing even sedentary duty. The claimant submitted medical evidence in support of these contentions.

Following pertinent development, the Office informed the claimant that his reasons for refusing the job offer were not acceptable and allowed him 15 additional days to accept the position. By decision dated September 31, 1997, the Office terminated the claimant's compensation benefits as he refused an offer of suitable work. "The Office found that evidence of record failed to establish that appellant's psychiatric condition was due to his October 15, 1996 employment injury and that appellant had a long history of psychiatric illness related to his military service." The claimant, through counsel, argued on appeal that the disabling psychiatric condition was a subsequently acquired medical condition.

The Board found that the Office failed to meet its burden of proof in terminating the claimant's compensation benefits for refusal to accept suitable employment.

The Board noted, "under the Office's procedures pertaining to suitable work, if the file documents a medical 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." The Board found that, once the issue of the claimant's disability due to his depression was raised by his attending physicians, the Office erred by not obtaining a medical opinion that the claimant could perform his duties as described in the offered position despite his emotional condition.

WAGE-EARNING CAPACITY - ACTUAL EARNINGS

Catherine K. Grabowski, Docket No. 00-1056, Issued March 6, 2001

This decision is similar to a number of decisions issued by the Board. The issue in all of these cases was whether the Office properly determined the claimant's wage-earning capacity based on actual earnings in a part-time position.

In this case, the claimant's attending physician found the claimant capable of working four hours per day intermittently with physical limitations. He did not anticipate an increase in the number of hours per day the claimant would be able to work.

The claimant returned to work within the physical restrictions established by her treating physician. After working in this position for eleven months, the Office determined that this position fairly and reasonably represented the claimant's wage-earning capacity.

The Board found that the Office improperly determined the claimant's wage-earning capacity based on her actual earnings in a part-time position. Citing FECA PM 2-0814.7.a, the Board found that the claimant's date of injury job was full time but she was currently working only four hours per day.

The Board noted: "Because Office procedures for determining wage-earning capacity based on actual earnings require that the tour of duty be at least equivalent to that of the job held on the date of injury and because the record fails to show that appellant's tours of duty were at least equivalent, the Office abused its discretion in finding that appellant's actual earnings in this part-time reemployment fairly and reasonably represented her wage-earning capacity."

In cases where the claimant has returned to part-time employment and the date of injury job was full-time employment, the Office must consider all of the factors cited in FECA PM 2-0814.7.a and explain why the job fairly and reasonably represents the claimant's wage-earning capacity in spite of the tour of duty not being equivalent to the date of injury employment.

FECA CIRCULAR NO. 02-05 **December 31, 2001**

SUBJECT: SELECTED ECAB DECISIONS FOR APRIL - JUNE, 2001

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

The subjects addressed include: chiropractic treatment -necessary and reasonable treatment;

chiropractic treatment - monitored by a qualified physician; reconsideration - non-merit review; performance of duty - employer intrusion into private life; performance of duty - personal activity; termination of compensation - importance of preparing the statement of accepted facts when developing the medical evidence; wage-earning capacity - availability of position with previous employer; obstruction of medical examination - failure to provide requested medical records; impartial medical examiner - proper method of selection; reconsideration - advancing a relevant legal argument; overpayment - waiver when claimant is without fault; overpayment - without fault/not without fault; termination - proper pre-termination notice.

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)

CHIROPRACTIC TREATMENT - REASONABLE AND NECESSARY TREATMENT

Jean D. Terry, Docket No. 00-39, Issued June 21, 2001

The issue in this case was whether the Office properly denied reimbursement of payment for chiropractic services.

On November 8, 1995, the claimant filed a claim for traumatic injury for a low back injury. By decision dated November 3, 1998, the Office denied the claim for payment of chiropractic treatment as the treatment was not authorized by the Office nor done at the referral of the attending physician. In a letter dated November 5, 1998, from the claimant's attorney the claimant requested an oral hearing and submitted copies of medical reports from Drs. Show and Frank who opined that the claimant's diagnostic tests were consistent with subluxation in connection with her federal employment. By decision dated July 1, 1999 the Office hearing representative found that the record failed to support that the claimant's change of physician and services provided by the chiropractor were reimbursable under the Act.

The Board found that the Office did not exercise its discretion to determine whether Dr. Frank's or Dr. Show's unauthorized chiropractic care was necessary and reasonable. The Board opined that the Office must review the treatment conducted by Dr. Frank and Dr. Show, as well as the medical evidence of record, and make a determination on whether the treatment was necessary and reasonable.

Consequently, the Board set aside the Office's decision and remanded the case for further

proceedings to determine the reasonableness and necessity of chiropractic treatment.

CHIROPRACTIC TREATMENT - MONITORED BY A QUALIFIED PHYSICIAN

Susan P. Pastorino Docket No. 00-562, Issued May 16, 2001

The issue in this case was whether the Office properly denied reimbursement of payment for chiropractic services.

On December 4, 1993, the claimant filed a claim for traumatic injury for strained back muscles and left shoulder strain. By decision dated March 30, 1994, the Office denied the claim for continuing work-related residuals. In a letter dated April 8, 1994, the claimant requested an oral hearing. By decision dated February 2, 1995, the Office hearing representative determined that the record failed to support that the services provided by the chiropractor were reimbursable under the Act.

By letter dated October 6, 1998 the Office denied the claim for chiropractic care based on the fact that it never accepted the claim for a work-related subluxation. By decision dated February 25, 1999 the Office denied a request for reconsideration because the chiropractic care was not obtained as a form of physical therapy under the "direction and supervision" of the attending physician. An additional request for reconsideration was denied on August 25, 1999.

The Board found that the Office correctly terminated the chiropractic treatment. The Board determined that the attending physician was not "monitoring" the chiropractor's treatment sufficiently enough to control the direction of treatment.

The Board opined that the evidence of record failed to demonstrate how medical benefits for physical therapy and chiropractic treatment were related the accepted medical condition.

The Board affirmed the Office decisions dated August 25, 1999 and February 25, 1999. The medical evidence failed to demonstrate the nature of the chiropractic treatment and show how the attending physician was monitoring the claimant's progression under the chiropractor's physical therapy treatment.

RECONSIDERATION - NON-MERIT REVIEW

James R. Camps Docket No. 2000-1235, Issued April 18, 2001

In this case, the issue under consideration by the Board was whether the Office abused its discretion in refusing to reopen the claimant's case for a merit review.

By decision dated December 12, 1999 the Office denied a request for reconsideration 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 found that the Office properly denied reconsideration. The claimant had merely resubmitted medical evidence that was in file and had been considered prior to the Office's January 14, 1999 decision. The Board cited Title 5 U.S.C. sec. 8128 (a) and 20 CFR sec. 10.606 (b) (2) in making the determination. The Act places the burden for opening a case for reconsideration upon the claimant. The claimant must provide evidence that an error was made by the Office in its interpretation of a point of law, advance a legal argument not previously considered, or submit relevant and pertinent evidence not previously considered by the Office.

Since the claimant merely submitted a medical report, which the Office considered in its previous decision, the Board found that the Office properly denied the claimant's request for reconsideration. Thus, the Board affirmed the December 12, 1999 decision.

PERFORMANCE OF DUTY - EMPLOYER INTRUSION INTO PRIVATE LIFE

Dixie L. Booth, Docket No. 2000-1200, Issued May 7, 2001

The issue before the Board in this claim was whether the claimant sustained an emotional condition in the performance of duty.

The claimant made several unsubstantiated allegations that the Office found did not occur. However, she was able to establish that working in the box section, distributing mail and working the window, many times alone, were compensable factors of employment.

By decision dated June 10, 1998 the Office denied the claim for failure to establish that the claimed medical condition was causally related to a compensable factor of employment.

The Board found that the case was not in posture for a decision. One of the allegations, proven to have occurred but found not to be a compensable factor of employment, was not fully investigated by the Office. Thus, the Office could not make an accurate analysis of whether or

not the incident was a compensable factor of employment.

The Board stated, "The Office erred, however, in summarily determining that appellant being escorted to the doctor by the nurse, Ms. Hayes, on her time off from work without her consent or permission was an administrative matter within management's discretion".

Further investigation by the Office was needed to determine the employing agency's reasons for the nurse's action. The Office should have requested a statement from the employing agency outlining the reasons for its "intrusion" into the claimant's personal ("private") life. There is no evidence that the nurse was following up on a work-related issue.

The Office, in this instance, is obligated to assist the claimant by obtaining an explanation from the employing agency as to the exact reasons for its intrusion into her private life. Once the Office receives the explanation it can then provide "full rationale for its determination".

The case was remanded to the Office for a complete investigation into the reason(s) why the employing agency sent a nurse to accompany the claimant to a doctor's appointment while she was on her own private time (off duty) with no apparent connection to work.

PERFORMANCE OF DUTY - PERSONAL ACTIVITY

Cynthia Greene, Docket No. 2000-1445, Issued May 4, 2001

The issue under consideration by the Board was whether the claimant sustained an injury in the performance of duty.

On December 17, 1999 the claimant filed a traumatic injury claim for an alleged November 5, 1999 incident at work. The claimant stated that she received first-degree burns to her neck and upper back when she plugged her portable television/radio with headphones into an adapter at work. She also claimed to have second-degree burns on her ear and burnt hair.

The Office denied the claim by decision dated February 15, 2000 based on the claimant's failure to provide evidence sufficient to establish that the injury occurred in the performance of duty within the meaning of the Act.

The Board found that the claimant "was not engaged in an activity contributing to the accomplishment of her assigned duties." The Board explains further that there is no evidence "to suggest that the employing establishment by custom or practice encouraged the use of such equipment by employees while performing their postal duties. Further, the use of portable television/radios does not fall into a class of activity closely related to personal ministrations considered to be incidental to employment."

In its May 4, 2001 decision affirming the Office's February 15, 2000 decision, the Board made a

distinction between allowable activities such as a bathroom break or a coffee break and the use of entertainment equipment (i.e. televisions, radios). The Board has also put forth a standard for the Office to evaluate and gather evidence in order to determine what is and is not considered to be an encouraged custom or practice in a specific employing agency.

TERMINATION OF COMPENSATION - IMPORTANCE OF PREPARING THE STATEMENT OF ACCEPTED FACTS WHEN DEVELOPING THE MEDICAL EVIDENCE

Geneva Sheppert, Docket No. 2000-1964, Issued May 14, 2001

There were two issues before the Board in this case. However, the issue of interest pertains to the decision to terminate compensation benefits on October 12, 1999 for no continuing work-related residuals/disability.

The Office accepted a work-injury for a lumbosacral strain that occurred on February 21, 1994. The claimant left work on February 23, 1994 and returned to light duty on July 5, 1994. She returned to full time/light duty on October 17, 1994.

On April 14, 1997 the claimant filed a claim for a recurrence of disability beginning on April 4, 1997. The attending physician, Dr. Robert W. Morrison, M.D. (Board-certified orthopedic surgeon) supported the claim for recurrence by his medical report dated April 9, 1997. The doctor stated that the claimant had suffered a "new" lumbosacral strain and left sciatica because the light duty assignment was changed and the claimant was moved to a new work area that required heavy lifting.

The Office accepted a recurrence due to a change in the, "nature of her limited-duty assignment". Dr. Morrison filed several further medical reports providing results of diagnostic tests and diagnoses. Dr. Morrison now diagnosed spondylolisthesis at L3-4 and a disc bulge at L4-5. By his medical report dated January 27, 1998 the doctor opined that the claimant could not return to her full time regular duties as a nurse.

Based on the doctor's reports dated January 27, 1998 and February 9, 1998 the employing agency decided it could not accommodate the claimant's work restrictions. She was placed on the periodic rolls effective November 12, 1997.

On June 21, 1999 the Office initiated a second opinion specialist examination for the claimant with Dr. Albert Thrower, M.D. (Board-certified orthopedic surgeon). Dr. Thrower was provided with the case record and statement of accepted facts. Dr. Thrower's initial report, dated June 29, 1999 stated that the claimant did not have residuals of the lumbosacral strain and the current condition of lumbar strain was "likely related" to a motor vehicle accident that the claimant was recently involved in.

In a follow-up report dated August 15, 1999 Dr. Thrower, "opined that appellant had 'fully recovered from the lumbosacral strain' and that her injury did not affect her `underlying spondyloisthesis and degenerative disc disease".

As a result of Dr. Thrower's report the Office issued a proposed notice of termination on September 10, 1999. The Office found that the weight of medical evidence rested with his medical reports. The Office found that the claimant's work-related medical condition had ceased and there was no further condition or disability that was causally related to the work injury.

The claimant's attending physician responded by report dated September 22, 1999 wherein he found the lumbosacral strain, along with disc disease, was still active in the spine. Although the claimant continued to suffer from continuing work-related residuals, the attending physician felt she could return to work with the proper restrictions.

On October 12, 1999 the Office wrote a final decision to terminate compensation and medical benefits. The claimant requested a reconsideration on January 4, 2000, which was denied on March 18, 2000.

The Board found that Dr. Thrower's reports were not based on a complete and accurate history. The statement of accepted facts provided to the doctor left out several details concerning the claimant's return to work and recurrence of disability. Dr. Thrower's report stated the claimant returned to regular duty in October of 1997 when it was only a return to light duty.

The Board stated that:

The statement of accepted facts also is ambiguous regarding whether, after her initial employment injury, appellant returned to eight hours of regular or limited-duty employment and specifies that she resumed full-time work in October 1997 rather than October 1994. Therefore, Dr. Thrower's report is based on an incomplete factual history as he believed that appellant returned to her regular employment flowing her February 21, 1994 employment injury rather than limited-duty employment.

Dr. Thrower also failed to discuss the accepted work-related recurrence of disability beginning on April 5, 1997. It is never addressed as to whether the claimant made a recovery from this recurrence. The Board found his opinion to be "seriously diminished" in it's probative value.

The Board makes it clear that the statement of accepted fact is to include complete and accurate accounts of return to work issues and distinguish between light and full duty returns to work. The lack of an accurate explanation of the return to work issues will adversely affect the results of second opinion and IME reports.

As a result, the Office's decision dated October 12, 1999, which was based on Dr. Thrower's opinion, was reversed and the case remanded back to the Office.

WAGE-EARNING CAPACITY - AVAILABILITY OF POSITION WITH PREVIOUS EMPLOYER

David Rundell, Docket No. 1999-1974, Issued May 22, 2001

The issue was whether the Office properly reduced the claimant's compensation based on its determination that he had actual earnings as a supply clerk for thirty hours a week and whether this position reasonably represents the claimant's wage-earning capacity.

In a previous appeal involving this case the Board originally set aside the Office's March 9 and April 12, 1994 decisions denying modification of an Office decision dated March 4, 1992 for loss of wage-earning capacity.

The March 4, 1992 WEC decision found that the claimant had actual earnings as a supply clerk for eight hours a day. Although the Office denied modification of the decision on March 9 and April 12, 1994 the record contains a second opinion specialist report from Robert Po, M.D., a Board-certified orthopedic surgeon, that shows a change in the claimant's work-related medical condition. This had a direct impact on the claimant's work restrictions. Dr. Po reported that the claimant could only work in the position of a supply clerk four to six hours a day.

The Board found that this constituted a change in the claimant's medical condition and the March 4, 1992 WEC decision was subject to review and modification.

The Office modified the March 4, 1992 decision on August 15, 1996. The August 15, 1996 decision, which was effective February 7, 1994, stated that the position of supply clerk working six hours a day "fairly and reasonably" represented the claimant's wage-earning capacity.

The claimant requested a reconsideration of the August 15, 1996 decision that was issued following the initial remand. The Office denied the request on October 3, 1996. The claimant then appealed to the Board. The Board had to remand the case on November 27, 1997 for "reassemblage". The Office issued another decision on May 4, 1999. This decision, written in response to the Board's remand, again denied modification of the August 15, 1996 decision.

The Office did not account for the fact that its decision of August 15, 1996 was based the claimant's wage earning capacity for actual earnings. The claimant retired on December 17, 1993; therefore, he did not have actual earnings on February 7, 1994 (the effective date of the WEC). The second problem is that the Office did not verify the position for part-time work. There is no evidence that the claimant's employing agency had such work available for the claimant to perform.

The Board stated:

Additionally, there is no indication in the record that the Office sought information from the employing establishment regarding whether a position as a part-time clerk was available, as of the time the medical evidence established that appellant could no longer work eight hours a day and that appellant actually performed such position. As appellant did not have actual wages as a supply clerk at the time of the Office's redetermination of this wage-earning capacity determination, the Office cannot establish his wage-earning capacity using the actual earnings method.

The decision was reversed and remanded back to the Office with instructions to use procedures set forth for a constructed LWEC determination.

OBSTRUCTION OF MEDICAL EXAMINATION - FAILURE TO PROVIDE REQUESTED MEDICAL RECORDS

Raul Meyers, Docket No. 2000-1839, Issued June 25, 2001

The issue in this case was whether the Office properly suspended the claimant's compensation for obstruction of a medical examination.

The claimant has experienced three separate traumatic incidents at work. An injury was claimed on March 5, 1991, on August 7, 1991, and on July 29, 1993. The immediate case concerns the work-injury of July 29, 1993. On that day the claimant was responsible for opening up the employment establishment for business. While doing this, the claimant set off the silent alarm at the police station. The police approached the facility with guns drawn and a confrontation developed between the claimant and the police over access to the facility. The Office accepted the claim for post-traumatic stress disorder.

The case has been to the Branch of Hearings and Review twice with the latest decision issued on August 26, 1999. The case was remanded with the Office's April 28, 1999 decision set-aside for further development before the Office could terminate the claimant's compensation benefits.

As part of the hearing representative's remand order, the district office instructed the claimant to complete a release of medical information form so the Office could obtain medical records from the treating physicians. The Office was planning to conduct a second opinion specialist examination after the requested medical reports/notes were received from the treating physicians. Letter dated October 1, 1999 told the claimant that it was his responsibility for ensuring that the Office received the requested documentation. Since the Office did not receive the requested information, it issued a December 15, 1999 decision that suspended the claimant's compensation based on obstruction of a required medical examination.

The Board found that the sanction decision was issued improperly. The Office cannot invoke the sanction identified in the Act under Title 5 U.S.C. sec. 8123 (d) unless the claimant has been directed to attend a scheduled medical examination. In the immediate case the Office was merely requesting documentation from the claimant's attending physician. No appointment had been scheduled. Therefore, an obstruction of a medical examination could not have occurred. Also, the Office issued the decision without first providing the claimant with a 14-day letter. The Office is required to give the claimant an opportunity to explain his obstruction before a decision suspending compensation under Title 5 U.S.C. Sec. 8123 (d) is issued.

The Board reversed the Office's suspension and ordered that compensation be "reinstated retroactively".

IMPARTIAL MEDICAL EXAMINER - PROPER METHOD OF SELECTION

Lazarus E. Jackson, Docket No. 2000-1881, Issued June 19, 2001

The issue of interest for this case was whether the claimant was entitled to more than seven-percent permanent partial impairment of the left lower extremity.

On December 10, 1998 the Office denied any additional schedule award. The Office hearing representative, by decision dated September 21, 1999, issued a decision that increased the total schedule award to seven-percent PPI of the left lower extremity.

The Office issued a new decision on October 6, 1999 granting an increase of the 1994 award from five-percent to seven-percent. The claimant's attorney requested a hearing that was denied on January 13, 2000.

The Board found that the case was not in posture for an appeal.

The Board determined that the Office failed to properly select an Impartial Medical Examiner when making its decision to resolve a conflict of medical opinion between the second opinion specialist and the attending physician.

The Board reviewed the MARQUIS Directory for a listing of Dr. Lawrence L. Barr, M.D. Dr. Barr was chosen as the IME. However, the Board could not find Dr. Barr listed in the MARQUIS Directory, thus Dr. Barr could not have been identified by the Office through the PDS rotational system. The reason for this is that the PDS software only included doctors that had been included in the MARQUIS Directory. Since Dr. Barr was not in the MARQIUS Directory, he could not have possibly been in the PDS system used by the Office to chose IME doctors. Thus, he was not part of the rotational system and could not be used by the Office for an IME examination.

The case was remanded for referral to a new IME to resolve the conflict. The decisions of January 13, 2000, October 6, 2000, and September 21, 1999 were set-aside.

RECONSIDERATION - ADVANCING A RELEVANT LEGAL ARGUMENT

Pamela L. MacKenzie, Docket No. 2000-2251, Issued June 4, 2001

This issue for before the Board was whether the Office properly denied the claimant's request for reconsideration.

By decision dated August 17, 1998 the claimant's compensation was terminated, effective September 12, 1998 based on the fact that she refused a suitable job offer without good reason. There was no rationalized medical evidence to support the claimant's claim that she was restricted to working only on the day shift due to her work-related injury.

The claimant requested a hearing. In a hearing decision dated March 1, 1999, the Office hearing representative found that the job offer was suitable and that there was no rationalized medical opinion from the attending physician to support the claimant's contention that she had to work on the day shift because of work-related medical restrictions.

On September 10, 1999 the claimant filed a request for reconsideration. The claimant's legal argument consisted of her belief that the Office and her employer were in violation of the Rehabilitation Act of 1973. She claimed entitlement to "reasonable accommodation" under this statute.

The Board made it clear that OWCP is not an open venue for claimants to advance legal claims/arguments concerning issues and/or statutes outside of Title 5. U.S.C. 8101 et seq.

The Board reiterated the three criteria, which a claimant must meet, in order to proceed with a request for reconsideration by having the Office reopen the case for merit review. The claimant failed to meet any of the criteria. See, 20 C.F.R. sec. 10.606(b).

The Board stated:

The Office previously addressed her argument concerning the restriction to day work. Whether she is entitled to reasonable accommodation under another statue is irrelevant or immaterial to whether she is entitled to continuing compensation under section 8106 (c) of the Federal Employees' Compensation Act.
The Board affirmed the Office's decision dated March 20, 2000.

OVERPAYMENT - WAIVER WHEN CLAIMANT IS WITHOUT FAULT

Ralph W. Kastla, Docket No. 2000-1538, Issued April 19, 2001

The issue before the Board was whether the Office made a proper finding of an overpayment in the amount of $21,144.90 and whether the Office's refusal of a waiver for the overpayment constituted an abuse of discretion.

The overpayment resulted from an incorrect payrate used to pay the claimant's schedule award for 39% permanent partial impairment for the period of November 25, 1997 to December 5, 1998. The Office "improperly" used a payrate that included cost-of-living increases since 1979. The claimant was entitled to a payrate of $319.84 per week with an increase to $325.00 per week for cost-of-living on March 1, 1999.

The schedule award was paid using $426.45 per week as the payrate because of the incorrect CPI effective date beginning in 1979. The claimant was found without fault in the creation of the overpayment in the amount of $22,272.29. However, the Office determined that the overpayment must be repaid in full.

Based on information dated December 2, 1999 the Office reduced the amount of the overpayment due to the claimant's increased charitable donations. The overpayment was recalculated in the amount of $21,144.90.

The claimant argued that the Office should not collect the overpayment due to the belief it would be detrimental to his financial status under the Office's regulations for recovery of overpayment that "would defeat the purpose of the Act or would be against equity and good conscience".

The Board determined that the evidence of record failed to establish the Office abused its discretion or acted against equity and good conscience in denying a waiver.

The claimant's monthly income exceeded his expenditures by more than $100.00 dollars, and his assets totaled at least $35,003.20. The Board used C.F.R. 20. Sec. 10.437 that provided the defining elements of equity and good conscience rule for evaluating wavier of overpayments.

The claimant claimed that his financial position changed for the worse when he increased his charitable contribution by $3.900.00 and made home improvements in the amount of $18,112.94. The Board stated that, "The regulations provide that in order to establish that an individual's position has changed for the worse, it must be shown that the decision made would not otherwise have been made but for the receipt of benefits, and that this decision resulted in a loss".

The Office determined that the home improvements could not be considered a loss. The claimant had increased the value and/or comfort of his home and the cost of the improvements could be recovered if the home was sold. However, the Office correctly determined that the claimant's increase of charitable contributions, based on the incorrect schedule award payments, did meet the criteria for a loss.

Since the Office made this finding, the claimant's overpayment was recalculated in the amount

of $1,128.00. Therefore, the total overpayment debt was decreased from $22,272.29 to $21,144.90.

The Board found that the Office did not abuse its discretion of recovery of the overpayment. Since the claimant was not in receipt of compensation benefits, the Board found that it had no jurisdiction, in this case, to determine the method of collection.

The Board affirmed the Office's February 3, 2000 decision.

OVERPAYMENT - WITHOUT FAULT/NOT WITHOUT FAULT

Robert D. Kerley, Docket No. 2000-791, Issued May 22, 2001

There were several issues before the Board; however, the issue of interest is the Office's finding that the claimant was not without fault in the creation of an overpayment.

The decision is significant for the Board affirming the Office's September 13, 1999 WEC decision. The Office properly reduced the claimant's compensation benefits for actual earnings as a purchasing agent.

The Office properly found that an overpayment had been created in the case, too. However, the Board found that the Office improperly determined that the claimant was not without fault in creation of the overpayment.

The overpayment occurred because the claimant had a "greater wage-earning capacity than previously calculated". The Board found that the period identified in the overpayment of February 20, 1995 to August 14, 1999 was correct and the amount of $4,849.02 also was correct.

However the case was remanded to the Office in order to evaluate a waiver for recovery of the overpayment.

The Board reviewed C.F.R. 20 sec. 10.433 (a) in its decision. "An individual is with fault in the creation of an overpayment who:

(1)Made an incorrect statement as to a material fact which the individual knew or should have know to be incorrect; or
(2)Failed to furnish information which the individual knew or should have known to be material; or
(3)With respect to the overpaid individual only, accepted a payment which the individual knew or should have been expected to know was incorrect."

The Board found that the Office mis-applied the third standard in its evaluation of finding the claimant not without fault. The Board's reason is that the claimant could not have known nor been expected to have known that the money received during the period cited was incorrect. The Office supplied the original payment information in a wage-earning capacity decision. Thus, the claimant had every reason to believe that the monitory compensation payments were correct. The Office did not discover the error until the Board remanded the original wage-earning capacity decision and the Office issued a new wage-earning capacity decision on September 13, 1999. The Board determined that it is illogical for the Office to expect the claimant to know that he was being overpaid beginning in 1995 when the final decision, which brought to the

overpayment to light, was not issued until September 13, 1999.

Since the claimant was not at fault in the creation of the overpayment, the Board remanded the case to the Office so that a determination could be made on the issue for a waiver of the recovery of the overpayment.

TERMINATION - NOTICE OF PRE-TERMINATION

Winton A. Miller, Docket No. 1999-2559, Issued June 19, 2001

The issue was whether the Office properly terminated the claimant's compensation benefits.

This is the third Board decision on this case. The case had been previously remanded to the Office in order to develop medical evidence and later the Board found that a suitability ruling by the Office on a job offered by the employer was incorrect.

The immediate issues are the Office's April 1, 1999 decision terminating compensation and the May 13, 1999 decision denying modification of that decision.

The Board's decision dated August 25, 1998 reversed the Office's decision of October 11, 1995, and the Office was instructed to reinstate the claimant's benefits retroactive to the date of termination. The Office then issued a decision dated April 1, 1999 determining that the medical evidence in file established that the claimant no longer suffered from a work-related medical condition based on a medical report from 1996, which pre-dated the Board's August 25, 1998 decision.

The Board stated:

The Office's procedures provide that notice is required prior to termination in all cases where benefits are being paid on the periodic rolls. In the present case, appellant should have been reinstated on the periodic rolls and should have received compensation retroactively from the date of termination. He does not fall within one of the exceptions to pre-termination notice as he did not die, did not return to work, was not convicted of defrauding the government and did not forfeit his compensation benefits.

It is also important to note that the Office did not provide any further development of the medical evidence in file but relied upon a medical report issued in 1996.

Nevertheless, the Office did not follow its procedures, which require that a pre-termination notice be issued prior to termination of compensation benefits when a claimant is receiving periodic roll payments.

The Board continued:

Furthermore, as appellant had no indication in any form that the Office was again considering termination of his compensation benefits prior to the April 1, 1999 decision, the Board finds that it violated due process and elementary fairness to terminate appellant's compensation benefits.

The Board reversed the Office's May 13 and April 1, 1999 decisions based on the above stated findings.

FECA CIRCULAR NO. 02-06

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

The interest rate to be assessed for the prompt payment bills is 5.25 percent for the period of July 1, 2002 through December 31, 2002.

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 3.0 percent for the period of July 1, 2002 through December 31, 2002. Ordinarily, the rate of interest charged on debts to the Government is changed in January. However, this rate is changed in July if there is a difference of 2.0 percent or more, which is the case this year.

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

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

7/1/02 - 12/31/02	5 1/4%
1/1/02 - 6/30/02	5 1/2%
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%

DMS INTEREST RATES

7/1/02 - 12/31/02	3%
1/1/02 - 6/30/02	5%
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 CIRCULAR NO. 02-07

SUBJECT: CURRENT INTREST RATES FOR PROMPT PAYMENT BILLS AND DEBT COLLECTION

The interest rate to be assessed for the prompt payment bills is 5.5 percent for the period January 1, 2002 through June 30, 2002.

The rate for assessing interest charges on debts due the Government has changed. The interest rate for assessing interest charges on debts due the Government is 5.0 percent for the period of January 1, 2002 through December 31, 2002.

Attached to this Circular is an updated listing of both the Prompt Pay and DMS interest rates from January 1, 1985 through current date.

DEBORAH B. SANFORD
Director, Federal Employees' Compensation

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

1/1/02 - 6/30/02	5 1/2%
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%

DMS INTEREST RATES

1/1/02 - 12/31/02	5%
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**

SUBJECT: Statement of Accepted Facts

Claims staff are reminded that the procedure manual requires specific language concerning additional elements of a Statement of Accepted Facts (SOAF). Such language addresses how to divide a SOAF when both work-related and non-work-related elements are evaluated.

Chapter 2-0809-13(c) specifically states that:

> "To aid the physician, the CE should divide any SOAF containing both work-related and non-work-related elements into three parts labeled as follows:
>
> (1) Incidents Which Occurred in Performance of Duty.
>
> (2) Incidents Which Occurred That Are Not Factors of Employment.
>
> (3) Incidents Alleged Which the Office Finds Did Not Occur.
>
> Each incident should be numbered consecutively within the section to which it belongs."

Headings such as 'compensable' and 'non-compensable' should not be used to divide the elements of a SOAF, especially in stress claims.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 02-09

SUBJECT: Code changes for the Departments of the Air Force, Army, Defense, Health and Human Services, Navy, State, Treasury, and Veterans Affairs, and Other Establishments, Case Management Users' Manual, Appendix 4-7

The Case Management Users' Manual is being updated and revised to reflect multiple changes, including the addition of several new codes. For the Department of the Air Force, the Air Training Command is now called the Air Education and Training Command. For the Department of the Army, the Army Health Services Command is now called the Army Medical Command,

while the Army Ballistics Missile Defense Systems Command is now called the Army Space and Missile Defense Command. For the Department of Defense, two agencies have been renamed, and separate codes are established to reflect four different Department of Defense organizations. For the Department of Health and Human Services, the Health Care Financing Administration is now called the Centers for Medicare and Medicaid Services. For the Department of the Navy, the Naval Oceanography Command is now called the Naval Meteorology and Oceanographic Command. For the Department of State, the Bureau of European and Canadian Affairs is now called the Bureau of European Affairs. For the Department of the Treasury, a new chargeback code has been added for claims filed by employees of the Financial Crimes Enforcement Network. For the Department of Veterans Affairs, four chargeback codes have been added to reflect the creation of four VA National Cemeteries. Finally, in the Other Establishments section, a new chargeback code has been added to reflect injury claims filed by employees of the Office of Special Counsel.

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. 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	3080	Defense	Ballistic Missile Defense Organization
" "	3081	" "	Court of Appeals for the Armed Forces
" "	3082	" "	Defense Prisoner of War/Missing Personnel Office
" "	3083	" "	Defense Office of Economic Adjustment
Add	2145	Treasury	Financial Crimes Enforcement Network
Add	4397	VA	Abraham Lincoln National Cemetery, Elwood, IL
" "	4445	" "	Saratoga National Cemetery
" "	4455	" "	Ohio Western Reserve National Cemetery

" "	4472	" "	Dallas Fort Worth National Cemetery
Add	1431	Other Est	Office of Special Counsel
Change	3704	Air Force	from: Air Training Command to: Air Education and Training Command
Change	3310	Army	from: Army Health Services Command to: Army Medical Command
" "	3324	" "	from: Army Ballistics Missile Defense Command to: Space and Missile Defense Command
Change	3013	Defense	from: CHAMPUS to: TRICARE Management Activity
" "	3060	" "	from: Defense Civilian Personnel Center to: Defense Human Resource Activity
Change	1231	HHS	from: Health Care Financing Administration to: Centers for Medicare & Medicaid Services
Change	655x	Navy	from: Naval Oceanography Command to: Naval Meteorology & Oceanography Command
Change	1305	State	from: Bureau of European & Canadian Affairs to: Bureau of European Affairs

FECA CIRCULAR NO. 02-10

SUBJECT: Code changes for the Departments of Labor, Transportation, and Veterans Affairs, Case Management Users' Manual, Appendix 4-7

The Case Management Users' Manual is being updated and revised to reflect the addition of several new codes. For the Department of Labor, new code 1110 has been added to reflect the creation of the Division of Energy Employees Compensation Program. For the Department of Transportation, new code 2540 has been added to reflect the creation of the Transportation Security Administration. For the Department of Veterans Affairs, new code 4459 has been added to reflect the creation of Fort Sill National Cemetery.

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. 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	1110	Labor	OWCP - Division of Energy Employees Compensation
Add	2540	Transprtn	Transportation Security Administration
Add	4459	VA	Fort Sill National Cemetery

FECA TRANSMITTALS (FT)--INDEX

FECA TRANSMITTALS (FT)--TEXT

FECA TRANSMITTAL NO. 02-01 **January 14, 2002**

EXPLANATION OF MATERIAL TRANSMITTED: RELEASE - REVISION TO CHAPTER 2-900, DETERMINING PAY RATES, FEDERAL (FECA) PROCEDURE MANUAL

A paragraph has been added to clarify who qualifies as a career seasonal employee for pay rate purposes. "Substantially the whole year", is normally defined as at least 11 months. However, the normal work schedule for the teaching profession is less than 11 months. Therefore, "substantially the whole year" is not 11 months for teachers.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0900	6-16	2	2-0900	6-16

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. 02-02 **January 14, 2002**

EXPLANATION OF MATERIAL TRANSMITTED: RELEASE - REVISION TO CHAPTER 1-0200-2, GENERAL JURISDICTION, PART 1 – MAIL AND FILE, FEDERAL (FECA) PROCEDURE MANUAL

Chapter 1-0200-2 is revised to transfer the responsibility for claims adjudication and case management of claims for employees and their relatives of the Office of Workers' Compensation Programs in the Midwest (formerly Chicago) Region (Illinois, Indiana, Michigan, Minnesota, Wisconsin, Ohio, Iowa, Kansas, Missouri, and Nebraska).

The OWCP claims originated in the Midwest Region have in the past been sent to the Kansas City district office (District 11) for adjudication and management. Now that the Kansas City district office (District 11) has been assigned to the Midwest Region it is necessary to avoid any possible conflict of interest in the claims being adjudicated and maintained under the same region in which the injured employees (and their relatives) work and report.

All new claims for OWCP employees and their relatives, in the Midwest Region, will be created in and fall under the jurisdiction of the National Operations Office (District 25). All existing claims for OWCP employees and their relatives, in the Midwest Region, will be transferred to the National Operations Office (District 25) for case management.

This requirement will be specifically stated through revision of paragraphs 1-0200-2(g)(2) and 1-0200-2(l) of the FECA Procedure Manual.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
1	1-0200-2	1-6	1	1-0200-2	1-6

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

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

FECA TRANSMITTAL NO. 02-03 **February 25, 2002**

RELEASE - REVISION TO CHAPTER 2-1602, RECONSIDERATIONS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-1602 is revised to modify the FECA procedures in accordance with the new Federal regulations, which were approved and made final on November 25, 1998, and made effective on January 4, 1999. Upon review of the new regulations you will note that the part specifically pertaining to the reconsideration process starts at Subsection 10.605 and concludes at Subsection 10.610. Several section numbers changed and require update to conform to the revision of the Federal regulations.

Both paragraphs of Chapter 2-1602 3.b were updated to reflect the correct section number of Title 20 of the Code of Federal Regulations (CFR). The new CFR references is 20 CFR 10.607(a) rather than 20 CFR 10.138. The reference to 28 CFR 10.131(a) (assessing the timeliness of a hearing request) was removed.

Paragraph 3.d. of Chapter 2-1602 was also updated. Reference to Title 20 CFR Part 10.138(b)

was changed to Title 20 CFR Part 10.608(b).

Also, paragraph 5.b. of Chapter 2-1602 was updated to include the fifth edition of the Guides effective February 1, 2001.

Finally, Exhibits 2 and 4 of Chapter 2-1602 were revised to reflect the new CFR references. The revised changes are 20 CFR 10.607(b) and Section 10.607(a) respectively. Other than the changes stated above, pages were repaginated with no change in the contents.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1602	i	2	2-1602	i
		1-8			1-10
		Exs. 2 & 4			Exs. 2 & 4

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

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

FECA TRANSMITTAL NO. 02-04 **February 25, 2002**

RELEASE - REVISION TO CHAPTER 2-1200, FEES FOR REPRESENTATIVES' SERVICES, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Changes have been made to Chapter 2- 1200-7(a) page 8, to reflect revised limits for fee approval by district office personnel.

Claims Examiners (Grade 9-12) are authorized to evaluate fee requests up to $10,000. Senior claims examiners are authorized to evaluate fee requests up to $15,000, and Supervisory Claims Examiners are authorized to evaluate fee requests up to $50,000. Fee requests over $50,000 should be evaluated by the Assistant District Director or District Director.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1200	8	2	2-1200	8

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

Distribution: Claims Examiners, All Supervisors, District Medical Advisers, Technical Assistants, and Rehabilitation Specialists.

FECA TRANSMITTAL NO. 02-05 **February 26, 2002**

RELEASE - REVISION TO CHAPTER 2-0811, EARLY MANAGEMENT OF DISBILITY CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL EXPLANATION OF MATERIAL TRANSMITTED:

Changes were previously made to Chapter 2-0811 in accordance with FECA Bulletin 97-04 and FECA Transmittal 97-17. One of the changes was to delete the obsolete reference to the 'Short Term Roll' (previously section 10). All changes referenced in the bulletin and transmittal were made in the FECA procedure manual. Unfortunately, the Table of Contents was not updated in folioviews.

This transmittal is being issued for the purpose of updating the Table of Contents for Chapter 2-0811.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0811	i	2	2-0811	i

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

Distribution: Claims Examiners, All Supervisors, District Medical Advisers, Technical Assistants, and Rehabilitation Specialists.

FECA TRANSMITTAL NO. 02-07 **April 18, 2002**

RELEASE - REVISION TO CHAPTER 2-900, DETERMINING PAY RATES, FEDERAL (FECA) PROCEDURE MANUAL EXPLANATION OF MATERIAL TRANSMITTED:

A paragraph has been added at PM 2-900.4.a.(2) to clarify that teachers are not subject to the provisions for career seasonal employees since working "substantially the whole year", in the teaching profession, would be less than 11 months.

A paragraph has been added at PM 2-900.7.b.(22) to incorporate the provisions of the Federal Firefighters Overtime Pay Reform Act of 1998 into the increments of pay which may be included in the employee's pay rate.

PM 2-900.8.d. has been added to incorporate the methods of computing the pay rate for federal firefighters covered under the Federal Firefighters Overtime Pay Reform Act of 1998.

Minor changes have been made to the entire chapter to correct references to forms that have been revised, letters that have been revised, other PM chapters that have undergone revision in the past, etc.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0900	i-27	2	2-0900	i-28

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. 02-08 **April 22, 2002**

RELEASE - REVISION TO CHAPTER 2-200-2 (e), GENERAL PROVISIONS - PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL. REVISION TO CHAPTER 2-700-2, DEATH CLAIMS, PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL. REVISION TO CHAPTER 2-901-18, OTHER PAYEES, PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUEL.

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-200-2 (e) is revised to show that any compensation payment, not just death benefits, is subject to the new federal law regarding garnishment of FECA benefits in order to pay for past due alimony and child support payments.

Chapter 2-700-2 is revised to show the change in federal law that allows compensation payments from FECA, including survivor benefits, to be garnished in order to collect overdue alimony and child support payments. All requests for garnishment must be submitted with proper documentation from a state agency or a court order.

Chapter 2-901-18 is revised to show that the state/municipal agency or court that issues the garnishment order should be classified under "other payee" for compensation purposes.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	0700	i&1	2	0700	i&1
2	0901	i,29,30	2	0901	i, ii 29,30
2	0200	i,2,3,4,5,6	2	0200	i,2,3, 4,5,6

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

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

FECA TRANSMITTAL NO. 02-11 **August 26, 2002**

RELEASE - REVISION TO CHAPTER 2-1700, SPECIAL ACT CASES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-1700, paragraph 8 has been added to this chapter to include guidance on handling the claims of contract observers on vessels. The addition of this paragraph incorporates the information contained in FECA Bulletin 97-13 issued June 4, 1997.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1700	i	2	2-1700	i, 17

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

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

FECA TRANSMITTAL NO. 02-12 **August 30, 2002**

RELEASE - REVISION TO CHAPTER 2-0808, SCHEDULE AWARDS AND PERMANENT DISABILITY CLAIMS,PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Changes have been made to Chapter 2-0808, paragraphs 6. a., 6.d.(1) and 7.b.(4), to reflect that we currently use the AMA Guide to the Evaluation of Permanent Impairment, Fifth Edition, effective February 1, 2001. All permanent partial impairment awards determined on or after the effective date of the Guides, regardless of the date of the medical examination, should be based on the fifth edition.

Also, paragraph 8 on Disfigurement has been revised to remove the requirement that the claimant personally appear before the Assistant District Director in a disfigurement claim. Paragraph 8.d., OWCP Medical Evaluation, fully describes the new process. The District Medical Advisor will make his or her assessment based on the medical evidence and photographs in file. Paragraph 8.e., with the previous heading of "Interview in District Office," is replaced with the final section, Payment of Award.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages	
Part	Chapter	Pages	Part	Chapter
2	2-0808	i	2	2-0808
		5-8		
		11-13		

Pages

i

5-8

11-13

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, Technical Assistants, Rehabilitation

Specialists, and Staff Nurses)

FECA TRANSMITTAL NO. 02-13 **August 29, 2002**

RELEASE - REVISION TO CHAPTER 3-0700, SCHEDULE AWARDS, PART 3 – MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 5 on Disfigurement has been revised to remove the requirement that the claimant personally appear before the Assistant District Director in a disfigurement claim. The paragraph fully describes the actions of the District Medical Advisor (DMA) in the new process. The DMA will make his or her assessment based on the medical evidence and photographs in file. Also, in the event that maximum medical improvement has not been reached, the DMA will continue to offer an opinion as to whether the option of plastic surgery will improve the appearance or decrease the degree of disfigurement.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
3	3-0700	i 7-8	3	3-0700	i 7-8

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, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

OWCP BULLETINS (OB)--INDEX

OWCP BULLETINS (OB)--TEXT

OWCP CIRCULARS (OC)--INDEX

OC 02-01 **Reimbursement Rates for Travel**

OWCP CIRCULARS (OC)--TEXT

OWCP CIRCULAR NO. 02-01 **January 25, 2002**

SUBJECT: Reimbursement Rates for Travel

Effective January 21, 2002, the mileage rate for reimbursement to Federal employees traveling on official duty by privately-owned automobiles was increased to 36.5 cents per mile by the General Services Administration. As in the past, this rate has been made to apply to injured employees involved in approved rehabilitation activities (under the maintenance allowance and prior-authorized travel to and from a residential facility), rehabilitation counselors under the OWCP-35 and specific authorization by the Rehabilitation Specialist under the OWCP-16 and OWCP-24, and contract field nurses under the supervision and management of the Staff Registered Nurses.

Effective immediately all injured employees, counselors, and field nurses should be advised of the new rates in effect and the date of applicability.

The rates are to be released in the Federal Register.

Cecily Rayburn
Director, Division of
Planning, Policy and Standards

List No.5 All FECA and LHWCA Claims Examiners,

Supervisors,Rehabilitation Specialists, Systems Managers,Technical Advisors, and FECA Staff Nurses

OWCP TRANSMITTALS (OT)--INDEX

OWCP TRANSMITTALS (OT)--TEXT

Endnotes

1 (Popup - Popup)

[1] There was an error made by the Bureau of Labor Statistics (BLS) in calculating the CPI figure for 2000 and 2001 (see OMB Bulletin 01-04 for reference). The 2000 increase was erroneously reported as 2.7% instead of 2.8%, and the 2001 increase was reported as 3.4% instead of 3.3%. OWCP issued a supplemental payment equivalent to 0.1% for all claimants entitled to CPI increases for the period of 03/01/00 to 02/28/01 to correct the shortfall. For purposes of consistency, the current CPI figures (2.7% and 3.4%) were kept in the system, rather than adjusting to the corrected BLS figures.