BCT-FY03

This infobase contains a numerical index of all **FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 2003**, 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. 03-01

Issue Date: January 16, 2003

Expiration Date: January 16, 2004

Subject: Compensation Orders/Letter Decisions - Signature Authority for Journey Level GS-12 and Senior Claims Examiners

Background: In the past, Senior Claims Examiners (SrCEs) exercised signature authority for most formal decisions. Since the office has upgraded journey level claims examiners (CEs) from a GS-11 to a GS-12, most formal decisions can now be prepared for the signature of the journey level GS-12 (general) CE.

The signature authority (approvals/denials) of GS 5-11 CEs is not affected by the contents of this bulletin or the attachment.

Reference: FECA Procedure Manual Chapter 2-807.10b, Chapter 2-808.7a, and Chapter 2-1400.2d.

Purpose: To advise claims staff of the changes in signature authority for some formal decisions.

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

Actions:

1. Without written desisgnation from a Supervisory Claims Examiner (SCE) or higher authority, the signature authority outlined in this bulletin should not be delegated below the General GS-12 CE level.

2. The attachment should serve as a guide and/or reference with respect to signature authority and certification levels for GS-12 CEs (including seniors).

3. General CEs at the GS-12 level should exercise signature authority to deny the following: initial claims for traumatice injury and occupational disease; claims for recurrence; claims for continuation of pay (COP); requests for medical treatment, equipment, or supplies; requests for surgery; claims for schedule awards in hearing loss cases with no rateable loss; and periods of intermittent wage loss where the claimant has not met the burden of proof to establish entitlement to compensation.

4. GS-12 General CEs should adjudicate most complex disability and death cases.

5. General GS-12 CEs have signature authority to release Form CA-181, Award of Compensation when certifying a payment for a schedule award. (Note: Lump sum schedule award calculations must also be approved by a SCE.)

6. SrCEs are to have signature authority and responsibility for reconsideration decisions.

7. SrCEs are to have authority to approve and/or deny the full range of highly complex disability and death cases.

8. SrCEs are to have signature authority on preliminary notices of proposed reduction/termination of benefits, and for final decisions on reduction/termination of benefits.

9. Both the SrCEs and General GS-12 CEs are to have signature authority for no wage loss (zero LWEC) decisions based on the claimant's current employment.

10. After DD or ADD review, disallowances of disfigurement awards, should be prepared for the signature of the SrCE.

11. Disallowances, reductions and terminations not mentioned above should be prepared for the signature of the SrCE.

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

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

Attachment FB 03-01-x1
SIGNATURE AUTHORITY (APPROVALS/DENIALS/CERTIFICATION)

General GS-12 CEs

* Traumatic Injury Claims
* Occupational Disease Claims

* Most Complex Disability and Death Cases
* Medical Treatment, Equipment, Supplies
* Surgery Requests
* Recurrences
* Non-Rateable Hearing Loss
* COP
* Intermittent Wage Loss
* Payment Certification ($0-15,000; including signature on CA-181 when certifying payment whithin prescribed limit) Note: Lump sum schedule award calculations must also be approved by a SCE.
* 0% LWECs

SENIOR CLAIMS EXAMINERS

* All items listed under General GS-12 CE
* All Complex Disability and Death Claims (approval/denial)
* Proposed Terminations & Final Terminations
* Proposed Reductions & Final Reductions
* LWEC Modifications
* 8106c Decisions; Rehabilitation Sanction Decisions
* Disallowance of Disfigurement Awards
* Suspension or Forfeiture of Benefits
* Rescission of acceptance
* Housing or Vehicle Modifications
* Reconsiderations
* Certification of Placement on the PR for TTD, LWEC or survivor benefits. Certification of OPM/VA Election Letters
* Certification authority $0-$50,000

SUPERVISORY CLAIMS EXAMINER OR HIGHER LEVEL

* Payments in amounts greater than $50,000 must be verified/signed by a Supervisory Claims Examiner (SCE), GS-13 or higher level. This authority may be delegated to a SrCE in writing for a specific period of time, for example while serving as acting SCE. The SrCE should relect such authorization in the case file by signing the payment as 'Acting SCE'

* SCE - Attorney Fees ($0-$50,000)

* DD or Add Attorney Fees > $50,000

Expiration Date: January 27, 2004

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

Background: Effective January 1, 2003, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobile was *reduced* to 36.0 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 1, 2003 may be adjusted to reflect this decrease.

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

Instructions for Submitting Travel Vouchers

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/supply was provided, or more than one year beyond the calendar year in which the claim was first accepted by the Office, whichever is later (CFR §10.803)

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 to December 31, 2002	36.5 cents per mile
January 1, 2003 and after	36.0 cents per mile

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

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

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

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

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

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

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

INSTRUCTION CA-77
Revised January 2003

FECA BULLETIN NO. 03-03

Issue Date: January 27, 2003

Expiration Date: January 27, 2004

Subject: ADP - Automated Compensation Payment System (ACPS) Schedule for 2003.

Purpose: To provide the 2003 schedule for processing the periodic disability and death payrolls under the ACPS for calendar year 2003.

BCT-FY03.nfo

Applicability: Appropriate National Office and District Office personnel that need to be aware of both the periods and "cut-off" dates for the ACPS periodic disability, death, and weekly payrolls.

Disposition: This Bulletin should be retained in front of Part 5, Benefit Payments, Federal (FECA) Procedure Manual, until the indicated expiration date.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

Attachment

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

Attachment

AUTOMATED COMPENSATION SYSTEM (ACPS) - 2003

FECA DISABILITY PAYROLL - EACH 28 DAYS
FECA DEATH PAYROLL - EACH 28 DAYS

CHECK CYCLE	PERIOD OF ENTITLEMENT FROM TO	BI-WEEKLY PAY PERIODS FOR HEALTH AND LIFE INSURANCE PURPOSES	DISTRICT OFFICE CUT-OFF DATE	N.O. TRANSMISSION TO TREASURY
1	12/29/02– 01/25/03	12/29/03 – 01/11/03 01/12/03 – 01/25/03	01/15/03	01/17/03
2	01/26/03 – 02/22/03	01/26/03 – 02/08/03 02/09/03 – 02/22/03	02/12/03	02/14/03
3	02/23/03 – 03/22/03	02/23/03 – 03/08/03 03/09/03 – 03/22/03	03/12/03	03/14/03
4	03/23/03 – 04/19/03	03/23/03 – 04/05/03 04/06/03 – 04/19/03	04/09/03	04/10/03

5	04/20/03 – 05/17/03	04/20/03 – 05/03/03 05/04/03 – 05/17/03	05/07/03	05/09/03
6	05/18/03 – 06/14/03	05/18/03 – 05/31/03 06/01/03 – 06/14/03	06/04/03	06/06/03
7	06/15/03 – 07/12/03	06/15/03 – 06/28/03 06/29/03 – 07/12/03	07/02/03	07/04/03
8	07/13/03 – 08/09/03	07/13/03 – 07/26/03 07/27/03 – 08/09/03	07/30/03	08/01/03
9	08/10/03 – 09/06/03	08/10/03 – 08/23/03 08/24/03 – 09/06/03	08/27/03	08/29/03
10	09/07/03 – 10/04/03	09/07/03 – 09/20/03 09/21/03 – 10/04/03	09/24/03	09/26/03
11	10/05/03 – 11/01/03	10/05/03 – 10/18/03 10/19/03 – 11/01/03	10/22/03	10/24/03
12	11/02/03 – 11/29/03	11/02/03 – 11/15/03 11/16/03 – 11/29/03	11/19/03	11/21/03
13	11/30/03 – 12/27/03	11/30/03 – 12/13/03 12/14/03 - 12/27/03	12/17/03	12/19/03

*ENDING PERIOD IS THE CHECK DATE
FOR EFT PAYMENTS, THE CHECK DATE WILL BE FRIDAY

********FECA DAILY ROLL SCHEDULE (WEEKLY)********

DATE OF CHECK	DISTRICT OFFICE CUT-OFF DATE TO ENTER DATA INTO ACPS	N.O. TRANSMISSION TO
EACH FRIDAY	PREVIOUS TUESDAY	WEDNESDAY

Issue Date: March 7, 2003

Expiration Date: January 1, 2004

Subject: Compensation Pay: Compensation Rate Changes Effective January 2003.

Background: In December 2002, the President signed an Executive Order implementing a salary increase of 3.10 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only includes the 3.10 percent increase in the basic General Schedule. Any additional increase for locality-based pay is excluded. The adjustment was effective the first pay period after January 1, 2003.

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 were effective with the first compensation payroll period beginning on or after January 1, 2003. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $110,682 per annum. The basis for the minimum compensation rate is the salary of $17,106 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 to increase the payment of compensation for disability claims to:

Effective January 2, 2003	Minimum	Maximum
Monthly	$1,069.13	$6,917.63
Weekly	246.72	1,596.38
Daily (5-day week)	49.34	319.28

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

Effective January 2, 2003	Minimum	Maximum
Monthly	$1,425.50	$6,917.63

Applicability: Appropriate National and District Office personnel

Reference: Memorandum for Directors of Personnel dated December 2002; and the attachment for the 2003 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 was January 26, 2003, no supplemental payroll was necessary for the periodic disability and death payrolls.

   b. The new minimum/maximum compensation rates are available in ACPS.

2. Adjustment of Daily Roll Payments. Since the salary adjustments are not retroactive, it is assumed that all Federal agencies have ample time to receive and report the new pay rates on claims for compensation filed on or after January 1, 2003. Therefore, it is not 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 – 01/02/03

49.34-74.01 246.72-370.05 49.34 246.72(986.88) 1,069.13
49.34-65.79 246.72-328.96

CA-843 – 01/02/03

319.28 1,596.38(6,385.52) 6,917.63

4. Forms. CP-150, Minimum/Maximum Compensation, were 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 were generated, informing them of potential changes to their compensation benefits.

The notices were 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. 03-05

Issue Date: March 7, 2003

Expiration Date: February 29, 2004

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 2003.

Purpose: To furnish instructions on CPI adjustment implementation of March 1, 2003.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 2.4 percent.

2. The increase is effective March 1, 2003, and is applicable where disability or death occurred before March 1, 2002.

3. The new base month is December 2002.

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

$ 6,917.63	per month
1,596.38	per week
6,385.52	each four weeks
319.28	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, 2003, 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, 2003 and the start date of the periodic and death payroll cycles is February 23, 2003, there will be a supplemental record created for the period March 1 through March 22, 2003. Effective March 23, 2003, 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 16, 2003, 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 13, 2003 AND MARCH 17, 2003.* ACPS data entry may resume on March 18, 2003.

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, 2003.

4. Forms.

a. Beginning with the compensation payment cycle that covers March 23, 2003 to April 19, 2003, 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	2.8%**1(1)**
04/01/80	7.2%	03/01/01	3.3%**1(2)**
09/01/80	4.0%	03/01/02	1.3%
		03/01/03	2.4%

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

FECA BULLETIN NO. 03-06

BCT-FY03.nfo

ISSUE DATE: May 9, 2003

EXPIRATION DATE: May 9, 2004

Subject: ADP - Code It Fast I-9 Coding Tool

Background: The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is used in the Division of Federal Employees' Compensation (DFEC) to identify the condition(s) accepted by the program as compensable. The ICD-9-CM code(s) and the accompanying narrative description(s) are present in the case file itself, the Case Management File (CMF), and in documents to the claimant and provider(s). The accepted diagnoses are of importance in case management issues such as the appearance of additional conditions, consequential injuries, and length of disability. They are also necessary for the accurate processing of medical bills.

The ICD-9-CM classification is a hierarchical system of coding, with three digit category codes, followed in many instances by more specific four and five digit diagnosis codes that pinpoint the anatomical location and the particular nature of the disease or injury. This higher level of specificity is of benefit for case management purposes and is of particular importance in the Central Bill Processing System that will be implemented shortly.

To help facilitate the use of more specific codes, the Office of Workers' Compensation Programs (OWCP) has purchased an electronic medical coding tool known as *Code It Fast I-9* (*Code It Fast*).

Code It Fast is a desktop application that enables the user to search and reference ICD-9-CM Volumes 1 and 3 from his or her desktop. It also provides the user with a tool that can be used to search for ICD-9 codes using narrative diagnoses or numeric code references. The program comes complete with Sticky Note and Bookmark features, and provides the same annotations and icons contained in the ICD-9 Coding books. The user's manual is available at http://www.ingenixonline.com/content/cifi9/. Online customer service is available at http://www.ingenixonline.com/content/techsupport/default.asp

Reference: FECA Bulletin 88-19 and 93-12.
Purpose: This bulletin will briefly describe some of the software features of the *Code It Fast I-9* software, including logins and passwords.

Applicability: Claims staff, and medical staff in the district offices and the National Office, including the Branch of Hearings and Review.

Actions:

1. *Code It Fast I-9* will be deployed to each user's desktop from the National Office. Users will receive notice of the availability of the program and the desktop icon will appear on their PC when available. The desktop icon should be used to access the program.

2. User Logins: Each time the user accesses *Code It Fast*, the User Login dialog box appears. A user name and password are required. Your user name must be at least 4 characters, but not more than 10 characters. Your user name and password can be saved for future logins by selecting save user name and password during login. Once logged in each user is uniquely identified and will have access to personal sticky notes and bookmarks. You can change your user password by selecting change user password from the file menu's administration option.

3. Performing a Code Search: The search box is used to enter search terms and narrow search results. The user can also type in a valid ICD-9 code in order to bypass the search and go directly to the tabular listing. Up to four key words or code numbers can be entered. *Code It Fast* searches all selected code set databases for a specific match based on the key words entered and the type of search option specified. *Code It Fast* also has an automatic spell check feature that ensures that the term entered is valid. If the search term is not valid, the search term alternative dialog box appears and alternative search terms are provided. The user's manual section entitled tips for entering search terms should be consulted for additional help in this area.

4. Viewing Search Results: After the user executes a search, the tabular results box displays matches found in all applicable code sets. The number of code matches found is referenced on the screen. Codes are displayed so that the most likely codes are listed first (by rank). Fourth and fifth digit ICD-9-CM codes are grouped under the primary code. CPT and HCPCS codes are grouped under the corresponding section or subsection. Matches to the search term results can be viewed in either the tabular listing or in the indexes for ICD-9-CM, CPT, and HCPCS codes.

Select the code from the tabular results box in order to view the full description. All neighboring codes in the adjacent tabular listing will also be displayed. The tabular listing also shows "excludes" and "includes" notes, as well as "code first" and "code also" references for ICD-9 Codes. CPT and HCPS codes in the tabular listing are grouped by section/subsection. This process is similar to looking up the code and the description in the ICD-9-CM, CPT, or HCPCS code book.

5. Code Specific Dialog Boxes for ICD-9-CM: This box can be used to view notes from the code book that specifically pertain to the selected code, and which provide further defining terms, clarifying information, and fifth digit information and includes and excludes notes. This box is accessed by selecting an ICD-9 code that has associated notes/references from the tabular listing. The user then clicks the notes button from the toolbar, or goes to the ICD-9 menu and selects ICD-9 section notes.

6. ICD-9 Annotations: From this dialog box one can view annotations that pertain to the code selected. Annotations provide explanations of medical terminology and descriptions for specific diseases or conditions. This box accessed by selecting an ICD-9-CM code that has an annotation from the Tabular Listing. Click either the Annotations button from the toolbar, or go the ICD-9 menu and select Annotations.

7. Additional Features:

a**. The History Menu** lists a trail of up to 15 previously viewed codes. This makes it easy to go back to a previous code selection during the current session.

b. **The Bookmark Dialog Box** is used to store, amend, and catalog lists of frequently used codes. To open the bookmark dialog box, click the bookmarks button, or select bookmarks from the view menu. The bookmark dialog box will not contain any codes when you first access the application. Once codes are added the bookmark dialog box will contain code number links which direct you to the appropriate code in the tabular listing. This feature also provides you with a description of the code and the category assigned when it was created. See the user's manual for more details on adding, editing and deleting bookmarks.

c. The user can **copy codes**, descriptions and modifiers into the Windows clipboard and paste them into other Windows applications. *Code It Fast*, provides two ways for copying information to the clipboard: Ctrl+C or the copy option under the edit menu. Either a code line or block of text must be selected before executing the copy command.

d. The user may add/edit comments to codes by using the sticky **notes feature**. Each code with a sticky note attached is flagged for user references. The Sticky Note dialog box is opened by either clicking the sticky note button on the main toolbar or selecting sticky notes from the view menu. As with bookmarking, sticky notes must be added to the dialog box. See the user's manual for details on adding, deleting or editing sticky

notes.

e. To **print** the code information that appears in any dialog box, simply click the Print button or select Print from the File menu. The Print Report dialog box will appear. The user must select the items to be print, click the Setup button to display the Print Setup dialog box, and click the Print button. See the User's Manual for Print Report Options.

8. *Code It Fast* should be introduced to office staff prior to its deployment. Training on this bulletin may be conducted at the district office's discretion.

9. Updates to the *Code It Fast* software will be through National Office deployment when such become available.

10. The National Office will continue to assess the accuracy of ICD-9 coding.

Disposition: Retain until incorporated in the FECA procedural manual.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

Distribution: List No. 2(Claims Examiners, All Supervisors, District Medical Director, Fiscal Personnel, Systems Managers, Technical Assistants and Rehabilitation Specialists)

FECA BULLETIN NO. 03-07

Issue Date: May 12, 2003

Expiration Date: May 12, 2004

Subject: Development and Adjudication of Claims for War-Risk Hazard Cases

Background: The Federal Employees' Compensation Act (FECA) provides payment of compensation for disability or death of an employee resulting from an injury in the performance

of duty. Section 8102(b) of the Act specifically extends coverage for injuries sustained by employees employed outside the continental United States or Alaska as a result of a "war-risk hazard." Terrorist activities will be considered a "war-risk hazard" if they are carried out by foreign groups (including terrorist groups) or foreign individuals targeting the United States or its allies. In view of various inquiries and concerns raised by other Federal agencies concerning terrorism, it is necessary to provide guidance and instruction to claims staff on handling claims that may arise under Section 8102 following a war-risk hazard.

A war-risk hazard is defined as a hazard arising during a war in which the United States is engaged; during an armed conflict in which the United States is engaged, whether or not war has been declared; or during a war or armed conflict between military forces of any origin, occurring within any country in which a covered individual is employed. The hazard may arise from any of the following: the discharge of a missile; action of a hostile force or person; the discharge or explosion of munitions; the collision of vessels in a convoy; or the operation of vessels or aircraft engaged in war activities. [See Section 8101(13) and FECA PM 4-0300.7c (1)–(5).] Section 8102(b)(2) of the Act provides that disability or death due to a war-risk hazard, or during or as a result of capture, detention, or other restraint by a hostile force or individual, sustained by an employee who is employed outside the continental United States or in Alaska constitutes a personal injury sustained

while in the performance of duty. This applies **whether or not the employee was engaged in the course of employment when the injury or death occurred or when he or she was taken hostage by the hostile force or individual.**

A hostile force or individual means a nation, subject of a foreign nation or individual serving a foreign nation who is engaged in war or armed conflict as defined by the FECA.

Under section 8102 (b), an employee who resides in the vicinity of his employment who is not living there solely due to the exigencies of his employment is only covered while in the course of his employment. For example, local hires are covered only while in performance of duty. Also, Section 8102(b) does not apply to an employee who is a prisoner of war or a protected individual under the Geneva Conventions of 1949.

It should also be noted that Federal employees abroad are not covered around the clock under all situations. Federal employees abroad who are in travel status or on a special mission are covered for activities reasonably incidental to their employment (e.g., eating, sleeping, and transportation). Federal employees who are abroad may also be covered under other doctrines of workers' compensation law such as the zone of special danger, the bunkhouse rule, the proximity rule, the positional risk doctrine or the rescuers doctrine. In such situations, coverage would be extended on a basis other than Section 8102(b) where applicable to the facts of a given case.

References: Title 5 U.S.C. Sections 8102(b), 8101(13) defining war-risk hazard; 8101(14) defining hostile force or individual; 8101(15) defining allies and 8101(16) defining war activities and Federal (FECA) Procedure Manual Chapter 4-0300.7c (1)-(5). See also War Hazards Compensation Act, 42 U.S.C. 1701 et seq. using the same definition of war-risk hazard; regulations implementing the War Hazards Compensation Act at 20 CFR Part 61 and 62, and FECA Bulletin 91-14.

Purpose: To provide instructions and guidance to claims staff that are responsible for developing and adjudicating claims that arise under Section 8102(b) of the Act due to a war-risk hazard.

Applicability: All district office and National Office staff.

Responsibilities: Cases believed to fall under the provision of Section 8102(b) of the Act, i.e., war-risk hazard cases, should be jacketed, adjudicated and managed in the National Operations Office (District Office 25). Some cases may be forwarded to the servicing district office (DO) based on the claimant's home of record after adjudication. (See FECA PM 1-100.5 for case jurisdiction).

Action:

1. Claimant. A civilian employee or eligible dependent claiming compensation due to injury or death based on a potential war-risk hazard must provide sufficient information for OWCP to adjudicate the claim. **A claimant may not necessarily identify a war-risk hazard as the basis of the claim and need not do so.** Except for the issue of performance of duty, the evidence required is the same as in all other FECA claims.

2. Employing Agency Responsibilities.

a. Employing agencies are required to report to OWCP any injury resulting in death or probable disability, and to submit any additional information requested by OWCP. The employing agency is also expected to provide evidence on its own behalf and aid the claimant in assembling and submitting evidence. Timely reporting of such cases is especially important, as evidence relating to war-risk hazards is best gathered contemporaneously. Employing agencies are encouraged to flag such cases for possible development of a war risk hazard.

b. Since coverage under Section 8102(b) of the Act extends the boundaries of performance of duty to include activities that routinely fall outside the scope of employment, OWCP must look to the employing agency to investigate the circumstances of an injury and provide information so that a decision can be made in a timely manner.

c. The employing agency has a responsibility to the claimant to investigate and provide evidence promptly, and respond in writing and/or by telephone to any inquiries from OWCP within the timeframe requested. All telephone communications with other parties should be documented and placed in the case record. Employing agencies are encouraged to communicate in writing

and/or by telephone with OWCP when they have additional evidence from other sources (i.e., third parties) that is pertinent to the development and adjudication of the claim. Such additional evidence should be shared with OWCP in an expeditious manner.

3. OWCP's Responsibilities.

a. The Claims Examiner (CE) must advise the claimant, the employing agency and/or the representative, if any, in writing of the type of evidence necessary to establish the claim. If appropriate, the examiner may advise the claimant that OWCP is considering extending coverage under 8102(b).

b. Information pertinent to the adjudication of the claim may be in the possession of the claimant, employing agency, investigative source and/or other governmental agency. If the CE determines that a third party is the best source for the information needed to adjudicate the claim, the employing agency should be contacted in order to ascertain whether the employing agency already has the evidence needed. If the employing agency does not have the evidence needed they should be instructed to obtain the evidence from the third party and submit it to OWCP. If appropriate, the employing agency may copy OWCP on any written correspondence to a third party. Alternatively, the employing agency should notify OWCP that such inquiries have been undertaken so that OWCP is aware of the employing agency's ongoing efforts to obtain additional evidence. If the employing agency is contacted by telephone the CE must document the case file with an Auto CA-110 and/or written correspondence when appropriate. All telephone requests for evidence needed to establish the claim should be confirmed in writing with copies to the claimant and/or the representative, if any.

c. In order to gather the information needed to establish whether coverage under Section 8102(b) of the Act should be extended, and whether the circumstances surrounding the occurrence of the injury constitute a war-risk hazard, the CE may ask the claimant, the representative (if any) and/or the employing agency specific questions concerning incidents leading up to, surrounding and following the injury. The questions will be detailed and case specific. They may include questions similar to the following:

(1) Please identify the location where the incident occurred in proximity to any United States governmental presence in the region, such as the United States embassy or other governmental entities, including the nature and extent of any United States military presence or the military presence of any allies of the United States. Is there armed conflict between military forces of any origin going on in the area?

(2) Were any other employees or witnesses from your department present on the date of the incident? Were any other federal employees or other individuals such as dependents injured in the incident?

(3) Does the employing agency know whether the CIA, FBI, or the State Department has any information as to whether the incident was the work of a foreign terrorist group or individual? (The term "terrorist group" refers to an identifiable organization or cause which uses violence to achieve political goals, and is considered a "hostile force or persons engaged in armed conflict." A "war-risk hazard" may therefore be present.)

(4) What general or specific warnings, if any, were given prior to the incident or have been subsequently given to personnel serving in the region regarding terrorist threats? Have any other incidents occurred which would indicate that United States personnel and/or citizens in the area have been targeted by any terrorist or terrorist groups?

(5) Does the claimant or employing agency have information that the incident occurred as the result of a war or armed conflict between military forces, or in a region within the country where civilian personnel are serving? Please identify the presence of any known military conflict in that country.

(6) Does the employing agency or the agency charged with investigating the incident (i.e., local police, FBI, CIA, State Department) have information about individuals responsible for the

attack? Does the investigating agency know if the attackers were members of or acting on behalf of an identifiable group that pursues its political goals through the use of violence; or that has taken up arms against the United States or against the government where the incident arose? (In such cases, coverage would be extended.)

d. Cases that potentially fall under the provisions of Section 8102(b) of the Act due to a war-risk hazard are sensitive in nature. Therefore, it may be necessary to send a second or third request to obtain the requested evidence. If after a second request, the employing agency fails to respond, a telephone call should be made immediately by the CE to obtain the status of the request for information and to learn the reasons that are causing the delay. If the employing agency fails to respond after the third request, the CE should advise district office management. District office management is responsible for contacting the National Office immediately for guidance on handling the claim.

e. **No adverse decision should be made until the National Office has been consulted.**

f. The CE is responsible for rendering a decision on each case as promptly as possible. It is essential that development and adjudication be expedited on cases involving a war-risk hazard. However, decisions in these cases should not be expedited at the expense of obtaining all relevant evidence from all appropriate sources. Compensation payments should also be made as expeditiously as possible.

Disposition: Retain until the indicated expiration date or until incorporated in the FECA Procedure Manual.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 03-08

Issue Date: May 23, 2003

BCT-FY03.nfo

Expiration Date: May 23, 2004

Subject: Medical Exams/IME: Board Certified Osteopathic Physicians in the PDS (Physicians Directory System)

Background: The OWCP policy of according special weight to the medical opinions of Board-certified specialists includes physicians certified by the American Osteopathic Association (AOA) as well as those certified by the American Board of Medical Specialties (ABMS). For some time there has been a question as to whether the special weight afforded by Board certification is equal among physicians who are certified by the ABMS and the AOA.

The original database for the Physician's Directory System (PDS), which OWCP uses for selecting referee physicians, was derived from the *Directory of Medical Specialists* published by Marquis Who's Who. This directory was compiled by the American Board of Medical Specialties (ABMS) which includes the medical boards of the American Medical Association that certify candidates in their respective fields of specialization.

In addition to the medical doctors (MDs) as described above, OWCP recognizes osteopathic doctors (DOs) as physicians within the meaning of the Act. OWCP also accords special weight to their opinions, provided they are Board-certified and it can be established that such certification has been verified with the American Osteopathic Association (AOA).

Reference: Federal (FECA) Procedure Manual, Chapters 2-810 and 3-0500.

Purpose: To further clarify OWCP's longstanding position that special weight is to be given to the opinion of a physician within the meaning of 5 U.S.C. 8101 who is Board-certified in an area of medical specialization; and to provide guidance to district office personnel with respect to adding osteopathic physicians to the PDS and selecting osteopaths for referee examinations.

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

Action:

1. Addinig Physicians to the PDS by the District Office Manager (PDS) administrator). since the original PDS database from Marquis Who's Who contained only MDs certified by the ABMS, there is currently no means of identifying DOs that have been added to the system. In order to remedy this situation, the following guidelines must be observed:

    a. The PDS administrator must verify board-certification of all physicians entered into the PDS database (i.e, both DOs and MDs).

(1) In the case of DOs this must be done via the American Osteopathic Association (AOA), and not the State medicla board (which can only verify that a physician is licensed and in good standing to practice medicine in the particular state).

(2) To document board certification of all physicians added to the PDS, the PDS administrator will maintain a file for each physician which contaians copies of the curriculum vitae and the information verifying the board certification from either the ABMS or the AOA, which ever is apppropriate.

b. When a doctor who is a DO is added to the system, the PDS administrator must enter a note in the physician's note field indicating that this doctor is an osteopathic physician.

c. The DO's area of board-certification will be entered in the field where the area of specialization is normally entered.

d. If the DO has a sub-specialty it must be entered into the subspecialty field.

2. Modifying the PDS to include DOs as distinguished from MDs. If it is recognized that a DO has been added to the PDS without a means of distinguishing him or her from the larger body of MDs in the system, the PDS administrator must enter a note designating the physician as an osteopath and indicate the specialty and subspecialty just as in the guidelines at 1a., 1b. and 1c above. This will be the only means of identifying osteopathic physicians in the database until such time as upgrades to the system and modifications to the database are loaded.

The above described procedures will be effective within thirty (30) days of the release of this bulletin. Please ensure that proper notification/training is provided to district office personnel that are affected.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 03-09

Issue Date: July 7, 2003

Expiration Date: July 7, 2004

BCT-FY03.nfo

Subject: BPS - OWCP-957 – Medical Travel Refund Request Form and Instructions for Submitting OWCP-957

Background: Effective August 12, 2003, new Form OWCP-957 should be submitted by all FECA claimants to claim travel reimbursement.

Reference: Federal (FECA) Procedure Manual Chapter 5-0200

Purpose: To notify all FEC staff of the new form to be used by FECA claimants for all reimbursements of travel.

Applicability: Appropriate National Office and District Office personnel.

Action:

1. Effective August 1, 2003, in all cases where a request for the form used to make a claim for medical travel reimbursement is received; the requestor should be provided with Form OWCP-957. Form OWCP-957 is needed for processing requests for medical travel reimbursement through the automated bill processing system. A copy of Form OWCP-957 is attached to this bulletin and may be reproduced at local levels. When a request for medical travel reimbursement is made on a standard travel form (SF-1012), the requestor should be advised that Form OWCP-957 is needed for all future medical travel reimbursement requests. Form OWCP-957 should be provided to the requestor when practical.

2. Instructions for Submitting Form OWCP-957, Medical Travel Refund Request, provide guidance for completion of Form OWCP-957 by FECA recipients. A copy of the instructions is also attached to this bulletin.

3. The National Office will arrange for an initial supply of Form OWCP-957 to be provided to each District Office. The form and instructions are available on the DFEC website at http://www.dol.gov/esa/regs/compliance/owcp/forms.htm.

Disposition: This bulletin should be retained until incorporated in the Federal (FECA) Procedure Manual.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

BCT-FY03.nfo

FECA BULLETIN NO. 03-10

Issue Date: June13, 2003

Expiration Date: June12, 2004

Subject: Fiscal - Change of Lockbox Depository Effective March 19, 2003

Background: In March 2003, the U.S. Treasury/Financial Management System (FMS) severed its ties with PNC Bank of Pittsburgh, PA. As a result, the current DFEC lockbox accounts were cancelled, requiring a new depository. FMS has since negotiated new agreements for the affected lockbox depository accounts with Bank of America in Atlanta, Georgia.

Purpose: To inform the appropriate personnel of the change in lockbox depository addresses, ensuring the proper processing of all incoming cash receipts.

Applicability: Appropriate National and District Office personnel. This includes each district office that previously had a lockbox account with PNC Bank. All DFEC lockboxes with an account apart from PNC Bank are not affected by this change, and their depository accounts remain the same. The current list of all DFEC lockboxes is attached to this publication.

Action:

1. All letters requesting payment to be mailed directly to the lockbox depository should be changed immediately. All letters pertaining to overpayment decisions (CA-2223, CA-2225, and the CA-9000 series) should be changed at each district office to reflect the new address as detailed in the attached listing.

2. DFEC System Managers have already been notified of the needed address change via e-mail, and should have modified the district office's "v44_lb_addr table." This update will also automatically update the Letter Generator System (LGS), since the LGS retrieves the lockbox addresses from this part of the v44 table through the "letters.cgi" when the "Generate Letter" button is clicked.

3. All other appropriate district office personnel must be made aware of the local lockbox address change.

4. As deposits sent to the old lockbox at PNC Bank will only be forwarded to Bank of America for approximately six months, the district offices affected must make every effort to inform any individual or organization that is sending cash deposits to the lockbox. This includes notifying entities such as medical providers and claimants with overpayments of the applicable address change.

5. All deposits mailed from the district office to the lockbox after March 19, 2003 should be mailed to the new lockbox address at the Bank of America.

6. It will also be necessary for each district office to identify all Office of Personnel Management (OPM) and salary offsets that are currently being mailed directly to its lockbox. The Cash Receipts Register will serve as a source for quick identification of such deposits. Notices must be sent to OPM and/or the employing agency immediately.

7. Deposit transactions will be made in the same manner as those previously made with PNC Bank. Transactions data will be sent from Bank of America to the district offices via FedEx. "Zero Activity" reports from Bank of America will not be forwarded, only daily reporting with actual deposit activity. The date of deposit will continue to be the Treasury confirmation date.

The contact person at Bank of America is Linda Thomas. Ms. Thomas can be reached by telephone at (770) 774-6430, and by e-mail at linda.j.thomas@bankofamerica.com.

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)

LOCKBOX DEPOSITY ADDRESSES

The following is a listing of the current mailing addresses for all DFEC lockboxes. This listing has been revised to include the new addresses for all lockboxes that have been switched from PNC Bank to Bank of America. All other district office lockbox addresses remain unchanged.

Boston District Office:

U.S. Dept. of Labor – DFEC Boston
P.O. Box 403498
Atlanta, GA 30384-3498

New York District Office:

U.S. Dept. of Labor – DFEC New York
P.O. Box 403484
Atlanta, GA 30384-3484

Philadelphia District Office:

U.S. Dept. of Labor – DFEC Philadelphia
P.O. Box 403471
Atlanta, GA 30384-3471

Jacksonville District Office:

U.S. Dept. of Labor – DFEC Jacksonville
P.O. Box 403376
Atlanta, GA 30384-3376

Cleveland District Office:

U.S. Dept. of Labor – DFEC Cleveland
P.O. Box 403459
Atlanta, GA 30384-3459

Chicago District Office:

U.S. Dept. of Labor – DFEC Chicago
P.O. Box 403449
Atlanta, GA 30384-3449

Kansas City District Office:

U.S. Dept. of Labor
Kansas City FECA Office
P.O. Box 845038
Dallas, TX 75284-5038

Denver District Office:

U.S. Dept. of Labor
Denver FECA Office
P.O. Box 60000
San Francisco, CA 94160-1251

San Francisco District Office:

U.S. Dept. of Labor
San Francisco FECA Office
P.O. Box 60000
San Francisco, CA 94160-1249

Seattle District Office:

U.S. Dept. of Labor
Seattle FECA Office
P.O. Box 60000
San Francisco, CA 94160-1252

Dallas District Office:

U.S. Dept. of Labor
Dallas FECA Office
P.O. Box 843537
Dallas, TX 75284-3537

Washington D.C. District Office:

U.S. Dept. of Labor – DFEC Washington D.C.
P.O. Box 403431
Atlanta, GA 30384-3431

National Office:

U.S. Dept. of Labor – DFEC National Office

P.O. Box 403356
Atlanta, GA 30384-3356

FECA BULLETIN NO. 03-11

Issue Date: August 29, 2003

Expiration Date: August 29, 2004

Subject: Forms – Foreign Payment Worksheet

Background: Foreign nationals are entitled to full medical benefits, including a choice of qualified physicians. Often, because of remote or undeveloped locations, employees will be treated at a Federal medical facility or may be transported to another country for treatment. Bills which have been approved for payment and in which payment is to be made to a foreign address must be forwarded to the National Office (District 50) for manual processing. All foreign bills, even those requesting reimbursement in U.S. dollars, will be sent to the National Office for payment, and should *not* be processed through the automated system.

Reference: FECA Procedure Manual, Chapter 4-0801-8(b)(2)

Purpose: To notify all employees of the existence of the new Foreign Payments Worksheet, and provide revised procedures for the handling of foreign bills.

Applicability: All staff.

Actions:

1. Processing Payments: All foreign payments that are received at the district office must be reviewed prior to submission to the National Office for payment. When it has been determined that the submission contains all appropriate information, the responsible claims staff at the district office must then compete Items 1–11 of the Foreign Payments Worksheet (Attachment 1). Particular attention should be paid to detailing the specifics of the payment request in Box 9 of the form. It is noted that *all* bills submitted for claimants residing in Germany will be paid as reimbursements directly to the claimant, due to strict German bill pay laws.

Once complete, the individual completing the form should initial the Worksheet in Box 10 of the form, and attach the Worksheet to the original source documents that generated the payment request. The entire packet should then be forwarded to the responsible Claims Examiner (CE)

assigned to the claim for certification. The CE has the responsibility to ensure that the submitted bills are in fact payable for that claim, and that the information listed on the Worksheet is accurate. Once certified by the CE, the entire packet should be forwarded to the appropriate staff for local imaging. The packet should be categorized as "Incoming Correspondence and Calls" in OASIS, with the attached Worksheet acting as the first page of the document. This will allow the image(s) to serve as a record of any foreign bills pending processing at the National Office.

The Worksheet should then be forwarded to National Office for payment processing. In order to confirm the accuracy of the data on the completed Worksheet, the National Office should review the submitted bills in the OASIS case record. The National Office will complete the SF-1166, and submit it to the Kansas City Financial Management Center (KC/FMS) for payment.

When the payment has been confirmed by KC/FMS, National Office staff will complete Items 12-17 of the Worksheet, detailing the payment specifics. A Foreign Payment Notification will then be sent to the claimant, indicating that payment is forthcoming and specifying the payment details (Attachment 3). A completed copy of the Worksheet, Foreign Payment Notification letter, and associated payment voucher from the KC/FMS will be sent to the ACS Central Bill Pay staff to update the bill history and then image as a paid bill.

2. Incomplete Payment Requests: If the district office staff cannot determine all the necessary specifics of a foreign payment request, they will immediately return the bills to the claimant. Attached to the bills will be the Foreign Bill Return letter (Attachment 2), explaining that the submitted bills cannot be paid due to the fact that key elements of the payment request cannot be identified. The letter will ask the claimant to provide the information necessary to pay the medical provider. In addition, a Form CA-915 (Claimant Medical Reimbursement Form) will be included in the return packet, to allow the claimant to provide the necessary information to allow reimbursement of expenses paid.

Disposition: Retain until incorporated in the 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 and Bill Pay Personnel)

Attachment 1

Foreign Payment Worksheet

U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	FOREIGN PAYMENT WORKSHE

1. Name	2. File No.
3. Amount of Payment Request	4. Accepted Condition(s)
5. Date to National Office	
6. Name of Payee and Payee's Address(Payment to be mailed to)	7. Claimant's Address
8. Type of Currency Being Paid	

9. Date(s) of Service	Provider Type	Amount

10. Prepared By:		11. Certifier(Initial and Date):	
12. Voucher Number	13. Check Number	14. Voucher Date	15. Amount Paid
16. N.O. Examiner(Initial and Date):		17. N.O. Certifier(Initial and Date):	

Attachment 2

Letter With Enclosed Bills recently Submitted

Claimant:
File Number

DATE

CLAIMANT NAME
STREET ADDRESS
CITY
COUNTRY

Dear Claimant:

The enclosed bills were recently submitted to our office in connection with your workers' compensation claim. However, additional information is required before the bills can be paid. Please provide the information needed on the lines provided below .

Date of Service	Service Provided	Amount

PLEASE NOTE: If you are seeking reimbursement of medical expenses already paid by you, please complete the enclosed Form CA-915.

If there are any questions concerning your claim or this form, please contact the Office at (XXX) XXX-XXXX.

BCT-FY03.nfo

Sincerely,

Claims Examiner

Claimant:
File Number:

Attachment 3

Letter - Total Payment

DATE

CLAIMANT NAME
STREET ADDRESS
CITY
COUNTRY

TOTAL PAYMENT:

Within the next several weeks, the U.S. Treasury will send a check to you at the address noted above. When received, the check will represent payment of the medical expenses that were recently submitted to our office for payment. The check will be issued in the foreign currency indicated on the bill(s).

If the bill(s) have been paid by you, please accept the check as your reimbursement; if the bill(s) have not been paid, please ensure that the appropriate medical provider(s) are paid upon receipt of the check.

If you have incurred additional medical expenses as a result of your employment-related injury, you may submit the bills to our Central Mail facility at the following address: DFEC Central Mailroom, P.O. Box 8300, London, KY 40742. Please be sure to include your claim file number (as shown on the top of this letter) on each item submitted, along with your current

mailing address.

Sincerely,

Special Examiner

FECA BULLETIN NO. 03-12

Issue Date: September 26, 2003

Expiration Date: September 26, 2004

Subject: BPS - Operational Guidelines for the Central Bill Processing system

Background: Effective September 2, 2003, OWCP began providing centralized bill processing (including most bill resolution/adjustment) for all of its DFEC district offices through Affiliated Computer Services (ACS). On August 13, 2003 ACS began to receive point-of-sale pharmacy bills. ACS is also providing medical authorization services. Bills should be mailed to: U.S. Department of Labor, DFEC Central Mail Room, P.O. Box 8300, London, KY 40742-8300. All bills should be sent directly to London, KY except foreign currency bills, bills for field nurse or rehabilitation counselor services, bills for OWCP directed medical examinations and bills for DMA review. Bills from contract nurses and rehabilitation counselors should be submitted electronically through the ACS web-portal.

Reference: Current version of the District Office Operational Rules and Processing Information document.

Purpose: To provide operating procedures for centralized bill processing.

Applicability: Claims Examiners, Senior Claims Examiners, All Claims Supervisors, Medical Schedulers, District Medical Advisors, Technical Assistants, System Managers, Staff Nurses, Vocational Rehabilitation Specialists, Communications Specialists, Fiscal Operations Specialists, Medical Coding Specialists, and Customer Service Representatives

Action:

1. Prior medical authorizations will be provided via telephone call and written correspondence

to ACS. Written medical authorizations will be mailed or transmitted to London, KY and scanned into both OASIS and SIR (Storage Information Retrieval) (SIR is the image system used by ACS).

a. ACS will continue to categorize all incoming mail; however, when a piece of mail is determined to be an authorization request, ACS will add a subject index in the OASIS file. This additional indexing will notify the claims examiner (CE) that ACS has processed that document as a medical authorization request, and the document has been imaged into SIR and reviewed by the prior authorization department in Tallassee.

b. If ACS needs to contact the district office regarding a written authorization request or a phone request, the responsible CE will receive an Omni-track thread from ACS concerning the requested medical service. The training material from ACS includes instructions on the use of Omni-track and the Prior Authorization process.

2. The toll free contact number for providers and claimants regarding medical billing is (866) 335-8319. This number should also be used to obtain a medical authorization. For faster service regarding medical bill inquiries, providers, claimants, and employing agencies may obtain information on-line at http://owcp.dol.acs-inc.com. Medical authorizations should be faxed to ACS for processing at (800) 215-4901.

3. Appropriate FEC personnel are to refer all pharmacy calls to ACS or to the web-site. If the pharmacy calls the district office regarding a medication that is not payable under the new system (and the pharmacy has already talked to ACS), the district office should state that the pharmacy cannot pursue the issue for the claimant any further. The pharmacy should be told that the issue is now a matter to be resolved between the treating physician and the CE. If the medication has been rejected by the treatment suite the CE should refer the request to the DMA for review of the medication and its use for treatment of the accepted condition(s). If the DMA opines that the medication is needed for treatment of the accepted condition the issue should be directed to the National Office, through the District Director, to determine if modification of the treatment suite is needed.

4. All staff nurses (SN) and vocational rehabilitation specialists (RS) should receive training on web-bill processing. The SN and RS will be responsible for reviewing and approving bills and reports submitted via the web-portal. The bills will be submitted to ACS for processing through the web-portal by the SN and RS. All field nurses and vocational rehabilitation counselors will need to enroll as providers with ACS. They will also need to sign a web-billing agreement form in order to log onto the web-portal and submit bills.

5. The toll free number for ACS will direct the caller to an IVRS that will be maintained by ACS. The caller, with the proper identifying information, will be able to access information about bill submission, prior authorization, and bill payment. The caller will be led through a series of menu options, designed to handle routine calls and inquiries, prior to being provided an option to speak with a customer service representative. Access to information will be limited in volume and time. The caller will be informed that the web-site is a better tool for gathering information several times throughout the call.

6. Effective immediately all GTRs submitted for payment should be forwarded to the National

Office fiscal officer for processing.

7. All payments for 100% wage loss due to the claimant's attendance at an OWCP directed medical examination should be processed through ACPS as a direct payment. If the case is under development or is in a denied status, a certification memorandum should be faxed to the National Office fiscal officer at (202) 693-1498.

8. Each district office should conduct training for its employees within 30 days of the issuance of this bulletin. It is recommended that employees receive training only on the systems they will specifically use to perform their duties.

Disposition: Retain until incorporated into the FECA Procedure Manual.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

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

FECA CIRCULARS (FC)--INDEX

BCT-FY03.nfo

FC -03-04 **Attachment 1 - PROMPT PAYMENT INTEREST RATES**

Attachment 2 - DMS INTEREST RATES

FECA CIRCULARS (FC)--TEXT

FECA CIRCULAR NO. 03-01 **December 2, 2002**

SUBJECT: DUAL BENEFITS - FERS COLA

Effective December 1, 2002, Social Security Benefits were increased by 1.4%. This required the amount of the FERS Dual Benefits Deduction to be increased by the same amount.

This adjustment was made from the National Office for all cases that were correctly entered into the ACPS Program. The adjustment was made effective with the periodic roll cycle beginning December 1, 2002.

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

SSA COLA's are as follows:

Effective December 1, 2002	1.4%
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%

BCT-FY03.nfo

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. 03-02 **September 5, 2003**

SUBJECT: SELECTED ECAB DECISIONS FOR JANUARY – MARCH, 2002

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

The subjects addressed include: forfeiture of compensation – effective date; performance of duty – premises doctrine; performance of duty – recreational and/or social activities; performance of duty – travel, special mission, or temporary duty; reconsideration – one-year time limitation

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)

FORFEITURE OF COMPENSATION – EFFECTIVE DATE

Brady L. Fowler, Docket No. 00-850, Issued January 11, 2002

In this case, the Office properly determined that the claimant had forfeited his right to compensation under section 5 U.S.C. § 8148. The interesting issue, however, was whether the Office had terminated the claimant's compensation on the proper effective date.

The Office terminated the claimant's compensation effective January 20, 1999, which was the date the claimant formally entered his plea of guilty to violating 18 U.S.C. § 1920. In its decision, the Board determined that the Office had improperly set the effective date of termination, explaining:

"Section 8148 specifically states that the forfeiture shall be effective as of the date of the conviction. The Office's regulation, found at 20 C.F.R. § 10.17, states that when a beneficiary under the Act pleads guilty to defrauding the government in connection with a claim for benefits, "the beneficiary's entitlement will terminate effective the date ... the guilty plea is accepted...." In this case, the Office used January 20, 1999 as the effective date of the forfeiture. However, the record shows that, while appellant entered his plea of guilty on January 20, 1999, the plea was not accepted by the judge until April 8, 1999 and guilt was adjudicated at that time. The date of the conviction is not the date appellant entered his guilty plea but the date that the plea was accepted and guilt adjudicated. The effective date of forfeiture of compensation, therefore, was April 8, 1999."

Consequently, it is imperative to remember that when terminating compensation under 5 U.S.C. § 8148, the claimant does not forfeit his or her right to compensation until the actual date of conviction.

PERFORMANCE OF DUTY – PREMISES DOCTRINE

Londa Lee, Docket No. 01-1183, Issued January 22,2002

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

The claimant filed a notice of traumatic injury alleging that she injured her right elbow and arm after tripping over a parking block. She indicated that the injury occurred at her duty station address. By letter, the Office requested that the claimant's employing agency indicate whether or not she was on premises that were owned and operated by the agency at the time of the alleged work injury. The employing agency never responded to the Office's request. By decision dated March 12, 2001, the Office denied her claim on the basis that she had failed to establish that she had sustained an injury while in the performance of duty.

In its decision, the Board detailed the Office's responsibilities when adjudicating a claim:

"In this case, the Office requested information from the employing establishment to ascertain whether the parking lot where appellant was injured was in its control. The employing establishment, however, did not respond to the Office's inquiry. Appellant should not be penalized for the failure of the Office to develop the evidence. Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While appellant has the burden to establish entitlement to compensation, the Office shares the responsibility in the development

of the evidence, particularly when such evidence is of the character normally obtained from the employing establishment or other governmental source.

The Board finds that the Office must make a determination on where the injury occurred and whether that location was considered to be on the employing establishment premises. The Office may not simply conclude, in light of the employing establishment's failure to respond, that appellant has not met her burden."

Accordingly, the Board found that the case was not in posture for a decision. The Office's decision was vacated and the case was remanded.

PERFORMANCE OF DUTY – RECREATIONAL/SOCIAL ACTIVITIES

James W. Hockaday, Docket No. 01-152, Issued March 25, 2002

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

The claimant filed a traumatic injury claim alleging that on August 18, 1999 he tore his left anterior cruciate ligament and left lateral meniscus while playing basketball at a training seminar. At the time of his injury, the claimant was attending a weeklong training course at Virginia Tech University. The Office denied the claim on the basis that the claimant had not sustained an injury while in the performance of duty.

The Board found that the claimant sustained an injury while in the performance of duty, and remanded the case for further development. The Board's decision is important because of its explication of issues concerning workers injured while at employer-sponsored events:

"When the degree of employer involvement descends from compulsion to mere sponsorship or encouragement, the questions become closer and it is necessary to conduct further inquiry. This inquiry focuses on the issues of whether the employing establishment sponsored the event and whether attendance was voluntary and whether the employing establishment financed the event. The record indicates that appellant's attendance at the training course was sponsored and paid for by the employing establishment and that the costs of the picnic, including the food and the rental on August 18, 1999 of the entire Blacksburg Recreational Center and all its associated facilities and equipment, were covered by the course fees paid by the employing establishments of the participants. In addition, the picnic was included in the course schedule as a regular meal activity and a special shuttle bus was arranged to carry course attendees to and from the picnic site, which was reserved for their exclusive use. Separately, each of these factors might not support that appellant was in the course of employment. However, under the circumstances, taking all of these factors together, the employing establishment can be said to have encouraged participation through sufficient financial control to bring the picnic within the course of

employment sponsorship. In addition, these factors further support a finding that the basketball game during which appellant was injured was reasonably incidental to the assigned activities of the training seminar itself and that, therefore, appellant's participation in the basketball game did not constitute the type of voluntary deviation from his regular activities which would remove him from the protection of the Act."

Accordingly, the Board ruled that the injury occurred in the performance of duty and remanded the case for further development.

PERFORMANCE OF DUTY – TRAVEL, SPECIAL MISSION, OR TEMPORARY DUTY

Trina Bornejko, Docket No. 01-1118, Issued February 27, 2002

The claimant filed a notice of traumatic injury alleging that she injured her ankle after slipping on ice while on the way to the airport for a temporary duty assignment. On two separate occasions, the claimant indicated that the injury occurred at her son's school, where she had stopped to drop him off while on the way to the airport. The Office denied the claim on the basis that the claimant had taken herself out of the performance of duty.

The Board affirmed the Office's decision, on the basis that the claimant's actions were not "reasonably incidental" to her work activities or travel assignment, explaining:

"The Board has recognized the rule that the Act covers an employee 24 hours a day when he or she is on travel status, a temporary duty assignment, or a special mission and engaged in activities essential or reasonably incidental to such duties. However, when the employee deviates from the normal incidents of his or her trip and engages in activities, personal or otherwise, which are not reasonably incidental to the duties of the temporary assignment contemplated by the employer, the employee ceases to be under the protection of the Act and any injury occurring during these deviations is not compensable.

At the time of her February 14, 2000 injury, appellant was on travel status, on her way to the airport, away from her regular place of employment. While on travel status she is covered 24 hours a day with respect to any injury that results from activities incidental to such duties. In this case, however, appellant acknowledged to her physician on February 14, 2000 that she hurt her ankle while dropping her son off at his school. She also stated this same fact in the March 23, 2000 conference call. Taking her son to school is personal in nature and does not constitute a normal activity reasonably incidental to her employment or travel assignment. As a purely personal pursuit, such activity constitutes a deviation from the performance of duty of an individual on travel status or on a temporary duty assignment, such that the 24 hour-a-day coverage under the Act does not apply."

RECONSIDERATION – ONE-YEAR TIME LIMITATION

Gwendolyn Thomas, Docket No. 01-1513, Issued January 18, 2002

In this case, the Office denied the claimant's request for reconsideration on the basis that the request had not been timely filed.

The Board remanded the case, holding that the Office had improperly determined that the claimant's request for reconsideration had been untimely. In its decision, the Board provides an excellent explanation of how to determine the timeliness of a reconsideration request:

"In this case, by letter dated April 12, 2001, appellant requested reconsideration of the Office hearing representative's decision dated April 12, 2000. The postmark of appellant's reconsideration request was not retained in the record. The date stamp indicates that appellant's letter was received on April 16, 2001.

It is well established under the Office's procedures that the timeliness of a reconsideration request is determined by the postmark of the envelope, but if the envelope is not available, the date of the letter itself is used. Thus, the date of appellant's letter, April 12, 2001, will be used to determine the timeliness of her request. The Board has also held that in computing a time period, the date of the event from which the designated period of time begins to run shall not be included, while the last day of the period so computed shall be included unless it is a Saturday, a Sunday or a legal holiday. As such, the one-year time period for appellant's reconsideration request began to run on the day after the Office's April 12, 2000 merit decision, or April 13, 2000. Since appellant's request for reconsideration was dated April 12, 2001, her request was timely."

FECA CIRCULAR NO. 03-03 **January 15, 2003**

SUBJECT: SELECTED ECAB DECISIONS FOR JULY - SEPTEMBER, 2001

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

The subjects addressed include: chiropractors – reimbursable services – transportation and incidental expenses; compensation – basic/augmented compensation – dependents; continuation of pay; idiopathic falls; medical expenses and treatment – services, appliances and supplies; medical expenses and treatment – transportation and incidental expenses; overpayments – waiver – defeat the purpose of the Act; performance of duty – deviation from duty; performance of duty – off-premises workers; performance of duty – premises doctrine; performance of duty – travel, special mission or temporary duty – deviation from duty; procedure on appeal to or review by the Board – jurisdiction of the Board; reconsideration under section 8128 – one-year time

limitation; recurrences of disability – following return to light duty; time limitation (section 8122) – pre-1974, one year/five year; schedule awards – hearing loss; schedule awards – hearing loss – audiograms; termination of compensation – abandonment of suitable work.

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)

CHIROPRACTORS – REIMBURSABLE SERVICES – TRANSPORTATION AND INCIDENTAL EXPENSES

Dennis W. Johnson, Docket No. 99-1808, Issued August 22, 2001

The issue in this case was whether the Office abused its discretion in denying the claimant's request for travel reimbursement for specialized chiropractic care.

The Office accepted that the claimant sustained subluxations at C2 and T2 and chronic thoracic myofascitis and strain as a result of a March 2, 1983 work injury.

Subsequent to the acceptance of his claim, the claimant submitted travel vouchers requesting reimbursement of $7,965.04 and annotating the mileage he had incurred in obtaining treatment from the date of injury through January 1998.

By decision dated July 27, 1998, the Office authorized mileage only for a 25-mile round trip to Harvey, ND. Consequently, only $598.12 of the requested reimbursement was authorized.

The claimant argued that the local chiropractor could not provide the specialized treatment he required and the nearest chiropractor who could provide that treatment, Dr. Torson, was located in Moorehead, MN, a distance of 396 miles per treatment.

The Board noted:

> "Medical expenses, along with transportation and other expenses incidental to securing medical care, are covered by section 8103 of the Act. This section provides that the United States shall furnish to an employee who is injured while in the performance of duty, the services, appliances, and supplies likely to cure, give relief, reduce the degree or the period of any disability or aid in lessening the amount of any monthly compensation. These services, appliances and supplies shall be furnished by, or on the order of physicians and hospitals designated or approved by the Secretary.
>
> The employee may be furnished necessary and reasonable transportation and expenses incident to securing of such services, appliances, and supplies. However, the Office has the general objective of ensuring that an employee recovers from an 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 it (sic) that of reasonableness."

The Board noted that the claimant chose to visit several chiropractors for treatment of his back condition. The closest treating chiropractor, geographically, to the claimant's home did not diagnose a subluxation as demonstrated by x-ray. Consequently, she could not be considered a physician under the Act and could not provide a valid referral to Dr. Torson. Dr. Torson, also, did not diagnose a subluxation as demonstrated by x-ray and, thus, also cannot be considered a physician under the Act. Moreover, since Dr. Torson performed services other than manual

manipulation of the spine such as acupuncture, these services did not constitute reimbursable treatment.

The Board explained:

> "The Act states that an employee may be furnished with necessary and reasonable transportation costs and other expenses incident to the securing of medical services. However, the determination of what is reasonable rests within the sound discretion of the Office. Reimbursable chiropractic expenses are limited to manual manipulation of the spine to correct subluxations. Thus, only chiropractors providing those services qualify for reimbursement, and any person trained as a chiropractor can provide that service. Therefore, the most reasonable chiropractic care could be obtained in the nearest town that has a chiropractor. In this case, that town would be Harvey, ND, up until February 1995 and after that the town would be Bismarck, ND. Therefore, it was reasonable that the Office reimburse only the travel costs to Harvey, ND up through January 1998."

The Board affirmed the Office's decision to reimburse mileage for a 25-mile round trip to Harvey, ND.

COMPENSATION – BASIC/AUGMENTED COMPENSATION – DEPENDENTS

Nancy J. Masterson, Docket No. 00-1434, Issued September 11, 2001

The issue in this case was whether the claimant was entitled to augmented compensation.

The Office accepted that the claimant sustained a right fifth metatarsal fracture in the performance of duty on May 4, 1998. She was paid compensation at the 66 2/3% rate based on no dependents.

By decision dated June 18, 1999, the Office determined that the claimant's husband did not constitute a dependent and, therefore, the claimant was not entitled to augmented compensation.

As the claimant's husband was not a member of the same household and there was no indication the claimant was ordered by a court to pay support, the issue was whether the claimant was providing regular contributions to her husband's support.

The claimant paid health insurance premiums for a plan that covered both her and her husband. This amounted to approximately $75.00 per month. (The difference between the family coverage and individual coverage.) The claimant also indicated that she made monthly payments for storage rental units that included property of her husband and she had contributed to her husband's health costs on an as needed basis.

> "The Board has held that, the test for determining dependency under the Act is whether the person claimed as a dependent, 'looked to and relied, in whole or in part, upon the contributions of the employee as a means of maintaining or helping to maintain a customary standard of living'. In the case of *Sam Ekovich*, the Board considered the situation where a spouse makes regular contributions for health insurance by paying for a health plan that covers both the employee and the spouse. In *Ekovich* the Board found that the spouse was not a dependent, but the decision is based on the factual finding in that case that the employee had never told his spouse that he had maintained health insurance coverage, and in addition the spouse had purchased her own coverage. Therefore the Board reasoned that the spouse could not have looked to and relied upon the contribution."

The Board remanded the case finding:

> "The record requires further factual development before a determination can be made as to whether regular contributions for health insurance are sufficient to establish the husband as a dependent. There is little evidence in the record as to the financial situation of appellant's husband. Appellant indicated that her husband had surgery in 1996 and was unable to get health insurance on his own, without further explanation. Additional relevant factual information would include the husband's current employment (if any), the amount of his income and monthly expenses (including medical expenses), and opportunities to purchase health insurance on his own. Such information is necessary in

order to make an appropriate determination as to whether the husband relied on the health insurance contributions to a degree sufficient to establish him as a dependent in this case."

CONTINUATION OF PAY

Laura L. Harrison, Docket No. 01-150, Issued September 27, 2001

The issue in this case was whether the claimant was entitled to continuation of pay. The decision contains an interesting discussion of the distinction between the requirement of section 8118(a) of the Act and section 8122 of the Act.

The claimant filed a form CA-1 on July 30, 1999 for an injury that occurred on June 14, 1999. The claimant stopped work effective June 15, 1999. The Office accepted the claim for right shoulder sprain and paid compensation for wage loss. However, by decision dated August 20, 1999, the Office denied the claim for continuation of pay as the claimant "failed to give written notice of injury within 30 days of the date of injury".

The claimant argued that she filed an AFMC Form 12 within 30 days of the injury and that form satisfied all the statutory requirements of section 8119 and that her immediate supervisor had sufficient written notice of injury within 30 days of the injury.

The Board noted that, while the claimant was correct in her argument, there is a critical distinction between notice of injury and a claim for compensation:

> "Section 8122 of the Act, entitled 'Time for making claim', provides that original claims for compensation for disability or death must be filed within 3 years after the injury or death unless the immediate superior had actual knowledge of the injury or death within 30 days or written notice of injury or death, as specified in section 8119, was given within 30 days. Actual knowledge and written notice of injury under section 8119 thereby serve to satisfy the statutory period for filing an original claim for compensation. This is not an issue in appellant's case because she filed her claim for compensation approximately 46 days after the injury. The Office accepted the claim as timely and paid compensation. Had appellant waited more than three years to file her claim for compensation, the AFMC Form 12 would be relevant to whether her claim was timely under section 8122.
>
> Claims that are timely under section 8122 are not necessarily timely under section 8118(a). Section 8118(a) makes continuation of pay contingent on the filing of a claim within 30 days of the injury. When an injured employee makes no claim for a period of wage loss within 30 days, she is not entitled to continuation of pay, notwithstanding prompt notice of injury. Appellant's AFMC Form 12 is not a claim for a period of wage loss and is not a form approved by the Secretary of Labor for purposes of claiming compensation. It provided notice of injury but is irrelevant to whether appellant is entitled to continuation of pay under 8118(a)."

The Board affirmed the Office's denial of continuation of pay. However, the Board noted that the Office's decision was misleading as it denied continuation of pay for failure to provide

"notice of injury" within 30 days. The more precise wording should have been that continuation of pay was denied for failure to file a "claim" within 30 days.

IDIOPATHIC FALLS

Adam Dumot, Docket No. 00-2317, Issued September 13, 2001

The issue in this case was whether the claimant was injured in the performance of duty.

The claimant alleged that he fractured his left hip on September 9, 1998 while getting out of his car. He alleged that he was reaching into the back of his vehicle for his canes when his left leg twisted under him and he fell to the ground. The claimant had a history of polio, colitis and left total knee replacement in 1989.

By decision dated November 6, 1998, the Office denied the claim finding that the injury was a result of a personal, non-occupational pathology and the claimant struck only the ground.

The evidence of record established that the claimant's duties required him to drive to many facilities in the course of his employment. On the date of the injury, the claimant had parked in his handicap parking space on the employing agency's premises.

The Board cited Larson:

> "(A) preexisting disease or infirmity of the employee does not disqualify a claim under the 'arising out of employment' requirement if the employment aggravated the disease or infirmity to produce the death or disability for which compensation is sought. This is sometimes expressed by saying that the employer takes the employee as it finds that employee."

The Board reversed the Office's decision opining:

> "Thus, the issue in this case becomes whether appellant's work duties aggravated his infirmity to produce the disability for which he is claiming compensation. Appellant was in the performance of duty when he reached for his canes while getting out of his vehicle to perform his employment duties. He fell and fractured his left hip as a result of this work activity. Therefore, the fall did not occur solely as a result of a non-occupational pathology, since there was contribution by the reaching into the back of the truck for his crutch. A review of the record shows that there is no credible evidence, either medical or factual, attributing appellant's condition to anything other than his employment. Both Drs. Bell and Anderson attributed appellant's injury to his fall at work. The evidence establishes that appellant's preexisting condition was aggravated by work factors and, thus, appellant sustained an injury while in the performance of duty."

Thus, the decision was reversed and the case remanded to the Office to determine the nature and extent of any disability causally related to the September 9, 1998 fall.

MEDICAL EXPENSES AND TREATMENT – SERVICES, APPLIANCES AND SUPPLIES

James R. Bell, Docket No. 99-2133, Issued July 2, 2001

The issue of interest in this case was whether the Office abused its discretion in denying the claimant's request to pay for electricity and water for an authorized whirlpool spa.

The Board affirmed the Office's decision.

> "As found in the Board's decision on appellant's prior appeal, the standard for the Office to apply in determining whether 'incidental' expenses, such as electricity and water for the authorized whirlpool spa in the present case is whether such expenses are necessary and reasonable. Regarding appellant's electricity and water expenses for operation of the authorized whirlpool spa, the Board stated, 'the payment of such costs as 'reasonable and necessary' for treatment of a job-related injury remains in the discretion of the Office'.
>
> In its most recent decision on the merits of appellant's claim, issued on April 29, 1999 the Office finally acknowledged that it is 'clearly true' that water and power are necessary for the operation of the authorized whirlpool spa. The Office found that the expenses for these utilities were not reasonable on the basis that persons other than appellant could use the whirlpool spa and appellant could use it recreationally in addition to therapeutically.
>
> The Board has recognized that the Office has broad discretion in approving services provided under section 8103 of the Federal Employees' Compensation Act, with the only limitation on the Office's authority being that of reasonableness. The Board finds that it was not unreasonable for the Office to deny appellant's request for (sic) pay for electricity and water for his authorized whirlpool spa. Although the Board on the prior appeal noted that appellant had not fully documented the costs of electricity and water, this was not the grounds on which the Board affirmed the Office's decision denying payment of these expenses. The Board found, 'While the facts in this case are such that a contrary factual conclusion might be reached, that alone does not establish that the Office abused its discretion.' This finding remains unchanged by the evidence appellant submitted subsequent to the prior appeal."

The Office's decision was affirmed.

MEDICAL EXPENSES AND TREATMENT – TRANSPORTATION AND INCIDENTAL EXPENSES

Dennis L. Jarzomkowske, Docket No. 00-913, Issued August 7, 2001

The issue in this case was whether the Office abused its discretion in denying the claimant's requests for reimbursement of medical treatment expenses.

By letter dated June 30, 1999, the claimant requested reimbursement of $1,393.41 for expenses related to medical treatment for the period May 23 through 25, 1999 and June 20 through 22, 1999. The expenses included $284.18 for prescriptions, $10.45 for telephone calls, $16.36 for fax service, $5.96 for special delivery by certified mail and $1,076.46 for miscellaneous. The latter amount constituted payment for his daughter as she drove him from Almoquedo, New Mexico to Phoenix, Arizona and back. He claimed 120.78 hours at $7.00 an hour for his daughter's time for a total of $845.46, car maintenance of $15.00 and the daughter's meal expenses at $36.00 a day for six days for a total of $216.00. In addition, the claimant filed a travel voucher for the same period claiming total reimbursement of $1,280.52 that represented $803.52 for mileage, $465.00 in total costs for food and lodging for him and $2.00 a day for six days as an other expense.

By letter dated June 30, 1999, the Office advised the claimant that his travel voucher had been reduced to $1,104.28 for actual travel expenses including food and lodging for the claimant at the per diem rate and mileage calculated at 31¢ per mile. The Office further advised that reimbursement for telephone calls, postage or fax service was not allowed. Further, there was no medical evidence to indicate that the claimant was unable to drive as a result of his accepted skin condition and, therefore, no attendant allowance was payable.

The Board found that the Office acted within its discretion in determining the amount of the allowable reimbursement and properly calculated the amount payable for food, lodging and mileage.

The Board further stated:

> "The Board has held that an attendant's allowance is appropriate when a claimant is so helpless that he is in need of constant care, as in being totally blind or being paralyzed and unable to walk. An attendant's allowance is not intended to pay an attendant for domestic and housekeeping chores such as cooking, cleaning, doing the laundry or providing transportation. In this case, there is no medical evidence that appellant is unable to care for himself or that his accepted skin condition has rendered him unable to drive. His personal decision to have his daughter accompany him to Phoenix for medical treatment is insufficient to entitle him to an allowance for this service.
>
> The Office properly determined that appellant was not entitled to reimbursement for telephone calls, fax service and certified-mail expenses made during the trip. Section 10.401(a) provides in part that a claimant is 'entitled to reimbursement of reasonable and necessary expenses, including transportation incident to obtaining authorized medical services, appliances or supplies'. The Board has held that incidental expenses are allowable only when incurred in the course of securing medical services and supplies. The telephone calls, fax service and certified-mail expense in this case were not part of

the process of securing medical services and supplies."

The Office's decision was affirmed.

OVERPAYMENTS – WAIVER – DEFEAT THE PURPOSE OF THE ACT

Dee Egbert, Docket No. 00-994, Issued September 27, 2001

There were several issues in this case. However, the issue of interest was whether the Office abused its discretion by denying waiver of the overpayment.

The Office determined that the claimant received an overpayment in the amount of $10,869.94 because an incorrect pay rate was used for compensation payments. The Office determined that the claimant was without fault in the creation of the overpayment. By decision dated January 5, 2000, the Office found that waiver of the overpayment was not warranted as the claimant and his wife had $82,230.00 in assets and that the claimant's income exceeded expenses by more than $50.00 because his clothing expense was excessive.

The Board found that the Office abused its discretion in denying waiver of the overpayment. The Board noted that the Office failed to consider any of the claimant's alleged $400.00 per month clothing expense and did not explain their reasons for excluding the entire amount.

In addition, the Board found that the Office erred in determining that the claimant's assets exceeded the resource base set forth in the FECA Procedure Manual by improperly including the separate property of his wife.

> "The definition of 'assets' in the Office's procedure manual, when compared to appellant's overpayment recovery questionnaire, shows that appellant's assets exceed this resource base only if his wife's checking, credit union accounts and stocks are included. However, appellant's wife kept her assets as separate property as they were part of an inheritance and thus retained the character of separate property under California law.
>
> The Board finds that the Office erred in determining that appellant's assets exceeded the resource base set forth in the Office's procedure manual by improperly including the separate property of his wife. The Board has held that a spouse's assets which are separately held and which are not normally considered reasonably available to meet ordinary and necessary living expenses are not available for purposes of determining the assets of an overpaid claimant. The Office could not recover appellant's overpayment from his wife's separate property under California law or Board precedents. (*Earl C. Poppel*, note 15; *Yolanda Librera*, 37 ECAB 388 (1986); *Marty Jocewicz*, 37 ECAB 233 (1985)) Thus, appellant's assets do not exceed the resource base of $5,000.00 set forth in the Office's procedure manual."

The Board affirmed the Office with regard to the fact and amount of the overpayment but remanded the case for additional development on the issue of waiver.

PERFORMANCE OF DUTY – DEVIATION FROM DUTY

Ronnie E. Banks, Docket No. 01-96, Issued July 19, 2001

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

The claimant, a city carrier, alleged that he was involved in a motor vehicle accident on May 6, 1999, and sustained a cervical strain and cephalgia.

The employing agency indicated that at the time of the accident the claimant was finishing his lunch break at a location that was not authorized by management. It was further noted that the accident occurred at a time other than the claimant's authorized lunch break.

The claimant advised that, at the time of the accident, he had finished his lunch and was on his way back to deliver mail. He noted that he had been eating at this particular restaurant on and off for the past three years. He further explained that he stopped for lunch late as he left the office for his route later than usual. His supervisor was aware that he took his lunch after he finished his business deliveries.

By decision dated October 28, 1999, the Office denied the claim on the grounds that the injury did not occur in the performance of duty.

The Board affirmed the Office's decision. The Board indicated:

> "In the present case, the evidence of record establishes the traffic accident involving appellant, a letter carrier, occurred on May 6, 1999 at 1:55 p.m. and that appellant sustained an injury as a result. At the time of the accident, appellant was returning to his route after eating lunch at an A & W restaurant. Appellant alleges that the accident occurred at a time when he was seeking personal comfort and, therefore, the deviation from his route was insubstantial and his injury occurred in the performance of duty...
>
> In the instant case, the employing establishment established appellant's authorized lunch stop at the Burger King restaurant. Rather than eating his lunch at Burger King, appellant deviated from his route and ate at an A & W restaurant, which was not an approved lunch spot. This case is similar to both *Johnson* (35 ECAB 695 1984) and *Bonilla* (37 ECAB 598 1986) in that appellant deviated from his accepted postal route, which removed him from being in the performance of duty at the time of the accident. Whether the employing establishment subsequently approved the A & W restaurant as an approved lunch spot is immaterial to the issue in this case. Because appellant was engaged in a deviation from his authorized route, his injury did not occur in the performance of duty."

The Office's decision was affirmed.

PERFORMANCE OF DUTY – OFF-PREMISES WORKERS

Kathryn A. Tuel-Gillem, Docket No. 00-2124, Issued July 18, 2001

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

On February 1, 2000, the claimant, a rural carrier, filed a notice of traumatic injury alleging that, on that day she fractured her right ankle when she slipped on ice in her driveway while walking to her private motor vehicle.

Based on a telephone conference, the Office established that the claimant was required to use her own vehicle in her job as a rural carrier. She drove to the employing agency each morning, cased mail from three to five hours, delivered mail on her route using her vehicle, returned to the employing agency and unloaded her car, then returned home. On the morning in question, the claimant was walking on the driveway in front of her residence approaching her vehicle when she slipped on ice and fell.

By decision dated May 5, 2000, the Office denied the claim on the grounds that the injury did not occur in the performance of duty.

The Board affirmed the Office's decision.

> "It is a well-settled principle of workers' compensation law that where 'the employee as part of his or her job is required to bring along his or her own car, truck or motorcycle for use during the working day, the trip to and from work is by that fact alone embraced within the course of employment'. Accordingly, an injury sustained while traveling to and from work may be within the performance of duty for that employee...
>
> Accordingly, because rural carriers may use their own transportation to deliver their routes, which is a benefit to the employer, they may be deemed to be in the performance of their duties when they are driving their vehicles to and from their route when they are required by the employing establishment to provide their own transportation. In this case, appellant was leaving her residence and approaching her vehicle to leave for work at the time of her injury. Regardless of whether she used her private vehicle in the course of her employment, the act of leaving one's residence to get to work would remain the same and is an activity that all employees engage in. There is a presumption that the trip to work of an employee with fixed hours and place of work is no different from that of any other employee with fixed hours and place of work. However, in the case of employees furnishing their own conveyance, such as rural carriers, coverage is extended when the employee is in the vehicle and driving to and from work because she is required to take her vehicle with her to perform her regularly assigned duties. It is at the point that she enters her vehicle that she would be considered to be in the performance of her duties."

The Board affirmed the Office’s decision.

PERFORMANCE OF DUTY – PREMISES DOCTRINE

Norma H. Godier, Docket No. 01-78, Issued July 17, 2001

This decision contained a concise discussion of the premises doctrine for employees with a "fixed premises".

On October 27, 1999, the claimant was walking to her place of employment when she tripped on an uneven sidewalk and fell, sustaining fractures of both patellae, an injury to her arm and contusions to her face. The employing agency was located in three floors of a building that were leased from a private owner. After appropriate development, the Office denied the claim finding that the claimant was not injured on the premises of the employing agency and therefore was not in the performance of duty at the time of the fall.

The Board affirmed the Office's decision explaining:

> "The evidence of record shows that appellant has fixed hours of work and was walking to the employing establishment when she fell. Her status, therefore, was that of a 'fixed premises' employee who is subject to the 'going and coming' rule generally applicable to such employees."

The Board further explained:

> "Under the facts of the case, it also cannot be said that appellant's injury occurred on the constructive premises of the employing establishment. The Board has determined that under certain circumstances, the employment premises may be constructively extended to hazardous conditions, which are proximately located to the premises and, therefore, may be considered as hazards of the employing establishment. The main consideration in applying this rule is whether the conditions giving rise to the injury are causally connected to the employment. In this case, appellant has not shown that the sidewalk was used exclusively or principally by employees of the employing establishment for the convenience of the employer. The employing establishment did not own the sidewalk and was not responsible for the maintenance of the sidewalk. Thus appellant's injury is considered to be an ordinary, nonemployment hazard of the journey to work itself, shared by all travelers. The case record does not establish that the sidewalk used by appellant was so connected with the employing establishment as to be considered part of the premises of the employing establishment. Therefore, appellant has not established that she sustained an injury in the performance of duty."

The Office's decision was affirmed.

PERFORMANCE OF DUTY – TRAVEL, SPECIAL MISSION OR TEMPORARY DUTY – DEVIATION FROM DUTY

William T. Bodily, Docket No. 00-1954, Issued September 25, 2001

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

The claimant alleged post-traumatic stress as a result of being robbed at gunpoint while on travel status. The employing agency controverted the claim, indicating that the claimant and his immediate supervisor left the vicinity of their hotel and went to a nightclub and were subsequently robbed at gunpoint during a personal deviation.

> "The record establishes that appellant and his supervisor, Donnie Benfield, were on temporary duty in Dallas, Texas from May 27 to 30, 1997 from their permanent duty station in Memphis, Tennessee. The men had completed their work duties on May 28, 1997 at approximately 4:00 p.m. and returned to their hotel. They left the hotel at 8:30 p.m. to find a restaurant recommended by a Dallas coworker. After driving for approximately an hour, they were unable to locate the restaurant. During this period, they made a stop at a convenience store and Mr. Benfield purchased a six pack of beer and cigarettes for their consumption 'in some of the shops on Deep Ellum'. After arriving in an area of Dallas identified by Mr. Benfield as Deep Ellum, the two men parked the car and started looking for a place to eat. After some time, they found a dining place at approximately 9:30 p.m."
>
> Appellant and Mr. Benfield alleged that they ate dinner, had several beers and stayed to listen to music until 11:30 p.m. As they prepared to leave, appellant went to the restroom and Mr. Benfield went outside to wait. A man, later identified as Tracy Gray, approached Mr. Benfield and stated that he was having car trouble. Mr. Gray mentioned that he was originally from Memphis and Mr. Benfield discussed being on temporary duty from that city. Mr. Gray told Mr. Benfield that he had a sister or cousin who lived nearby and asked for a ride. Mr. Benfield decided to help Mr. Gray, as he indicated the house was on the way back to the hotel. At 11:40 p.m., appellant joined Mr. Benfield outside, who related Mr. Gray's situation. Appellant and Mr. Benfield indicated that they spent 20 minutes talking to Mr. Gray before getting into the car.
>
> The men got into the car at 12:10 a.m. with appellant driving while Mr. Gray gave directions. Mr. Gray initially directed them towards Interstate 30, however, any discernable route is not available from the statement in evidence. They drove in various directions until 12:45 a.m. when Mr. Gray directed appellant to pull over. Mr. Gray produced a small handgun and demanded money from appellant and Mr. Benfield. He took $2,460.00 in cash and $100.00 in a traveler's check from appellant and $80.00 in cash from Mr. Benfield. Mr. Gray ordered the men outside the car and then drove off with the vehicle. Appellant and Mr. Benfield stated that they walked around until they found a telephone booth at 1:20 a.m. and called the police. Statements were taken and the men were subsequently escorted back to their hotel, arriving at 2:40 a.m.
>
> The report of the Dallas police indicates that the location of the robbery was the 1700 block of South Oakland Street. The police narrative states that at approximately 2:00

a.m., appellant and Mr. Benfield were at the corner of Elm and Walton Streets when they were approached by Mr. Gray, who asked for help to jump his car. When informed they did not have jumper cables, Mr. Gray asked them to take him to get some. They got into the rental vehicle and Mr. Gray directed them south on Oakland. Mr. Gray then produced a small black handgun and demanded their money. Mr. Gray then made the two men get out of the vehicle and took the rental vehicle. Appellant and Mr. Benfield then called the police. The report notes that at approximately 9:00 a.m. Mr. Gray was apprehended in the stolen rental car along with a female passenger. The police recovered a black .380 automatic, cash in the amounts of $1,150.00 and $646.00, appellant's wallet and traveler's check and a controlled substance."

By decision dated February 19, 1998, the Office denied the claim on the grounds that the claimant was not in the performance of duty at the time of the robbery.

The Board noted:

It is not disputed that when appellant was in Dallas he was on a business trip. He was directed by his employer to be in Dallas and was clearly serving his employer's interest in making the trip. The issue is whether appellant deviated from the business trip for personal reasons.

It is well established that 'an identifiable deviation from a business trip for personal reasons takes the employee out of the course of his employment until he returns to the route of the business trip, unless the deviation is so small as to be disregarded as insubstantial'. The initial question, therefore, is whether appellant deviated from a business trip for 'personal reasons'.

The claimant argued that, while driving with Mr. Gray they were traveling towards Interstate 30, thereby resuming the route to their hotel and completing any personal deviation.

The Board did not agree with the appellant's argument:

"The general rule is that, once a personal deviation has been completed and the main business route resumed, an employee is once again in the performance of duty. As Larson points out, 'the first step in a clear analysis of any deviation case is to draw a picture of the entire trip'. In this case, the picture drawn by appellant and Mr. Benfield is not one of clarity. The facts establish that appellant and Mr. Benfield were on a temporary duty assignment in Dallas and that they last performed duties related to their employment at 4:00 p.m. on May 28, 1997. Following their departure from the hotel for dinner, the time, place and location of their activities is not ascertainable from the record. After they left a restaurant at 11:30 p.m., appellant and Mr. Benfield met Mr. Gray, were robbed and left stranded in an unknown neighborhood. The record does not account for the approximately one and one-half hours between their departure at 12:10 a.m. with Mr. Gray and the arrival of the police at 1:35 a.m. Appellant and Mr. Benfield allege that they walked until they found a public telephone and they called the police at approximately 1:20 a.m. on May 29, 1997. Statements from appellant and Mr. Benfield

> further allege that the police told appellant that they were in a bad area, to remain on the street where the telephone was located and that the police would pick them up. The police arrived at approximately 1:35 a.m. on May 29, 1997, took statements and drove appellant and Mr. Benfield to their hotel.
>
> The Board finds that appellant did not complete his personal deviation and resume the main business route until the police drove him back to his hotel. The personal deviation ceased only when the police arrived to take appellant back to the hotel. Since the aggravated robbery occurred during a deviation for purposes that were personal in nature, appellant cannot be found to have been in the performance of duty when the incident occurred. Appellant was not engaged in activities reasonably incidental to his temporary duty assignment or to any activity directed by his employer."

The Board affirmed the Office's decision.

PROCEDURE ON APPEAL TO OR REVIEW BY THE BOARD – JURISDICTION OF THE BOARD

Anu Gupta (claiming as administrator of the estate of Krishan C. Shori), Docket No. 99-2326, Issued August 17, 2001

The Board dismissed this appeal and provided an interesting explanation of "adverse affect".

By decision dated June 8, 1999, the Office found that the position of library technician fairly and reasonably represented the claimant's wage earning capacity. The claimant appealed this decision and, subsequent to the docketing of the appeal, the claimant died.

The Board noted:

> "The Board has jurisdiction to consider and decide appeals from a final decision issued by the Office. The Board further notes that, pursuant to section 501.3, any person 'adversely affected' by a final decision of the Director, or his duly authorized representative, may file an application for review of such decision by the Board. In this case, the employee died prior to the adjudication of his appeal by the Board. The record reflects that the employee was being paid compensation under a schedule award that will expire on April 10, 2002. While the Office's June 8, 1999 decision contains findings which the employee considered to be adverse, the Board notes that, under the June 8, 1999 decision, the wage-earning capacity determination would not be effective until April 10, 2002, the date the employee's schedule award will expire. The Office so informed the employee in a letter dated June 17, 1999. As the employee died prior to the expiration of his schedule award, he would not be 'adversely affected' by the June 9, 1999 wage-earning capacity determination as it never became effective prior to his death. In light of these circumstances, there remains no adverse final decision over which the Board may take jurisdiction under 20 CFR section 501.3."

The appeal was dismissed.

RECONSIDERATION UNDER SECTION 8128 – ONE-YEAR TIME LIMITATION

Laureen Wall, Docket No. 00-2810, Issued July 19, 2001

This decision contains an explanation of when to consider the Board's decision as a merit review of the claim.

By decision dated April 15, 1996, the Office found that the weight of the medical evidence established that the claimant had no condition or disability after May 31, 1995, that was causally related to her accepted employment injury.

The Office denied a merit review of the claim as the claimant's June 25, 1997 request for reconsideration was untimely filed and failed to demonstrate clear evidence of error.

By decision issued June 1, 1999, the Board found that the claimant's June 25, 1997 request for reconsideration was untimely filed and that she failed to support her untimely request with clear evidence of error.

On May 17, 2000 the claimant again requested reconsideration. The Office again denied a merit review of the claim as the request for reconsideration was untimely filed and failed to demonstrate clear evidence of error.

The Board affirmed the Office decision noting:

> "As the Board noted in its prior decision, the last merit decision issued by the Office was its April 15, 1996 decision denying appellant's claim of recurrence. The Office subsequently denied appellant's June 25, 1997 request for reconsideration, but that decision, together with the Board's June 1, 1999 review thereof, were not decisions on the merits of appellant's claim for recurrence. Rather, they were decisions on whether the Office should reopen appellant's claim for a merit review of the recurrence issue, given the untimeliness of her request. Appellant had one year from the Office's April 15, 1996 decision to request reconsideration, and just as her June 25, 1997 request for reconsideration was untimely, so too is her May 16, 2000 request for reconsideration untimely."

The Office's decision was affirmed.

RECURRENCES OF DISABILITY – FOLLOWING RETURN TO LIGHT DUTY

Janelle Cali, Docket No. 00-402, Issued September 19, 2001

The issue in this case was whether the claimant had any continuing disability after March 17, 1997, causally related to the December 30, 1988 employment injury.

The Office accepted that the claimant sustained lumbar myositis and right knee sprain as a result of the December 30, 1988 work injury. The claimant stopped work on December 30, 1988, and returned to limited-duty work on March 26, 1990. She stopped work again on March 30, 1990.

On September 24, 1996, the employing agency offered the claimant a permanent modified general clerk position based on the results of an Office referred functional capacity evaluation and second opinion examination. The claimant accepted the position on March 6, 1997, and returned to work on March 17, 1997, for one shift. She called in sick on the following day and subsequently informed the Office that she planned to elect disability retirement. The claimant did not return to work.

On May 13, 1997, the claimant filed a recurrence of disability alleging that her disability on or after March 18, 1997, was causally related to the December 30, 1988 employment injury.

By decision dated March 16, 1988, the Office denied the claimant's recurrence of disability claim on the grounds that the evidence failed to establish that the claimant's current condition was due to the December 30, 1988 work injury based on a referee medical opinion that the Office obtained on November 17, 1997.

The Board affirmed the Office's decision noting:

> "When an employee, who is disabled from the job she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that she can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.
>
> In this case, appellant has not shown a change in the nature and extent of her modified-duty job requirements, nor has she submitted sufficient medical evidence to show a change in the nature and extent of her injury-related condition."

The Board further noted:

> "Appellant has the burden of proof to establish that her disability for work commencing March 17, 1997 and continuing was causally related to her accepted December 30, 1988 employment injury. Appellant has not met that burden of proof."

The Office’s decision was affirmed.

TIME LIMITATION (SECTION 8122) – PRE-1974, ONE YEAR/FIVE YEAR

David G. Evans, Docket No. 00-2788, Issued August 1, 2001

This decision contained a discussion of the timely filing requirements prior to 1974 as compared to the requirements after the 1974 amendments to the Act.

On December 12, 1998, a retired engineer filed an occupational disease claim alleging that he sustained employment-related hearing loss due to a two-week period of intermittent noise exposure in 1957.

The Office found that the claim for compensation benefits was barred by the time limitations of the Act. (The Office used the post-1974 time limitations in making their determination, however.)

The Board noted that the alleged injury occurred in 1957, prior to September 7, 1994, the effective date of the amendments that provided a three-year rather than a five-year time limitation. Therefore, the pre-1974 requirements should have been considered.

> "The Act, as applicable to this case, provides that a claim for compensation must be filed within five years from the date when the period of limitations begins to run. This provision is a maximum, mandatory requirement which may not be waived regardless of the reasons for, or the circumstances surrounding, the failure to file a claim within the prescribed time."

The Board went on to compare the pre- and post-1974 requirements:

> "The Act was amended in 1974 to provide a three year rather than a five-year maximum limitation period and to allow a claim not filed within that time if 'the immediate superior had actual knowledge of the injury or death within 30 days. The knowledge must be such to put the immediate superior reasonably on notice of an on-the-job injury'. The statute, however, specifically provides that the amendment to the time-limitation provision shall be applicable only to injuries occurring on or after the effective date of the amendments, September 7, 1974. As appellant's injury occurred over a period of time in 1957, the 1974 amendments do not apply to his case. Therefore, such knowledge by a supervisor would not fulfill the statutory requirement placed on appellant to file a claim so as to entitle him to compensation benefits. However, timely knowledge by appellant's superior would satisfy the notice requirement of the Act and entitle appellant to medical benefits for employment-related hearing loss."

Although the district office requested additional factual information from the employing agency, including noise levels, source of exposure, period of exposure, types of hearing protection provided and copies of all medical examinations pertaining to hearing or ear problems, no response was received from the employing agency. The claim was remanded to the district office for additional development to determine whether this information could be obtained in

order to determine whether the claimant met the notice requirement of the Act for entitlement to medical benefits.

SCHEDULE AWARDS – HEARING LOSS

Reynaldo R. Lichtenberger, Docket No. 01-381, Issued August 1, 2001

The issue in this case was whether the claimant had more than a 4% binaural hearing loss.

The Board found that the claimant was entitled to a schedule award for a 2% loss of hearing in his left ear and a 17% loss of hearing in his right ear.

> "Under the Act, the maximum award for binaural hearing loss is 200 weeks of compensation. Since the binaural hearing loss in this case is 4 percent, appellant would be entitled to 4 percent of 200 weeks or 8 weeks of compensation. The Office's October 26, 2000 decision awarded appellant eight weeks of compensation for a four percent binaural hearing loss.
>
> It is well established, however, that if calculations based on the monaural hearing loss would result in greater compensation, then the monaural hearing loss calculations should be used. (FECA Program Memorandum No. 49 issued November 26, 1974.) The maximum number of weeks of compensation for hearing loss in one ear is 52 weeks. The Office medical adviser found that the hearing loss in the right ear was 1.9 percent and in the left ear was 16.9 percent. Using the Office procedure of rounding to the next whole number (FECA Program Memorandum No. 49 issued May 1, 1967), the monaural losses are 2 percent and 17 percent. Two percent of 52 weeks is 1.04 weeks of compensation and 17 percent of 52 weeks is 8.84 weeks of compensation, resulting in a total of 9.88 weeks of compensation. As this is more than the 8 weeks of compensation for binaural hearing loss, the Office should have issued the schedule award for a 2 percent hearing loss in the left ear and a 17 percent hearing loss in the right ear. The Board, therefore, finds that appellant is entitled to an additional 1.88 weeks of compensation."

The Office's decision was affirmed as modified and returned to the Office for payment of the additional 1.88 weeks of compensation.

SCHEDULE AWARDS – HEARING LOSS - AUDIOGRAMS

John P. Ibanez, Docket No. 00-1369, Issued September 24, 2001

George M. Tomko, Docket No. 00-1991, Issued August 16, 2001

In the case of John Ibanez, the issue was whether the claimant established that he sustained more than a 17% binaural hearing loss.

On May 14, 1998, the claimant filed a notice of occupational disease alleging bilateral hearing loss as a result of his federal employment as a coal mine safety and health inspector. In additional to factual evidence, the claimant also submitted audiograms from 1975 to 1998.

The Office arranged for the claimant to be examined by a Board-certified otolaryngologist for a second opinion. Dr. Cullum found a binaural hearing loss of 25.625%. However, the Office's DMA found that Dr. Cullum's assessment of the claimant's hearing loss was worse than any previous reporting source and that his findings were unreliable. He recommended that the claimant be referred for another evaluation.

Consequently, the claimant was referred to Dr. Vongvises, a Board-certified otolaryngologist, for a second opinion. Dr. Vongvises found a binaural hearing loss of 17%. The Office's DMA agreed with Dr. Vongvises' evaluation and the claimant was awarded a 17% binaural hearing loss.

The Board found that the case was not in posture for a decision opining:

> "In the present case, Dr. Cullum's July 22, 1998 report and audiogram supported a hearing loss of 10 to 15 dBs higher than previous sources. The Office medical adviser stated that Dr. Cullum's report and audiogram could not be used to adjudicate appellant's claim because Dr. Cullum found a higher impairment than previous medical sources, in this case as well as other cases, therefore, Dr. Cullum's findings were not creditable. However, the medical adviser failed to provide sufficient explanation or evidence to support his allegation, such as the significance of a 10 to 15 dBs difference. The medical adviser did not suggest that Dr. Cullum's findings did not meet all the Office's standards, *e.g.*, the medical adviser did not suggest that there was anything wrong with the equipment used, or the testing procedures.
>
> Dr. Cullum's findings appear to be premised on his examination and testing of appellant and review of the record. A medical adviser may review any audiogram of record in determining which one most accurately reflects appellant's hearing loss, but must provide a rationalized explanation for his selection. When the only explanation given is a conclusion that a higher impairment of hearing loss was found, this is not sufficient to show that a report and audiogram do not constitute probative, reliable evidence. In this case, the medical adviser's statement concerning Dr. Cullum's creditability is unsubstantiated."

The Board remanded the case for the Office to determine which audiogram most accurately reflected the claimant's employment-related hearing loss.

In the case of George Tomko, the issue again hinged on the failure of the district medical advisor to explain why some audiograms should not be considered.

The Office arranged for the claimant to be seen by a Board-certified otolaryngologist on January 7, 1999. Based on the audiogram performed on behalf of the second opinion examiner, the Office accepted a work-related hearing loss but found that it was not severe enough to be considered ratable.

At an oral hearing, the claimant submitted an audiogram performed by a different Board-certified otolaryngologist on April 20, 1999. The case was remanded for clarification of what levels of hearing loss were related to the claimant's employment and which were related to non-occupational ear pathology.

The Office arranged for the claimant to again be examined by the second opinion examiner. Another audiogram was performed at that time which essentially duplicated the previous findings.

The Office again denied payment of a schedule award as the hearing loss was not ratable.

The Board noted that the Office failed to consider the April 20, 1999 audiogram, relying only on the two audiograms performed for the second opinion examiner.

The Board remanded the case for further development stating:

> "In cases where there were several audiograms of record, all made within approximately two years of each other, and submitted by more than one specialist, the Board has held that the Office must have all such audiograms evaluated to determine the percentage loss of each. The Office should not arbitrarily select one audiogram without explanation, even if the one selected is the most recent of record."

TERMINATION OF COMPENSATION – ABANDONMENT OF SUITABLE WORK

Manolo U. Mejia, Docket No. 00-759, Issued September 19, 2001

This decision contains an interesting discussion of abandonment of suitable employment.

The Office initially accepted that the claimant sustained a lumbosacral strain and a left shoulder strain as a result of a work-related injury.

On March 7, 1995, the Office advised the claimant that the position of cook, offered by the employing agency, was suitable and currently available. On May 1, 1995, the claimant accepted the offer of employment with no penalty. He began work on May 8, 1995, but stopped work after two or three days, filing a claim for continuing compensation on account of disability.

By decision dated July 18, 1995, the Office denied compensation for wage loss on the grounds that the medical evidence of record established that the claimant was capable of performing the duties of the position of cook.

On December 18, 1997, the claimant filed a notice of recurrence of disability alleging that he sustained a recurrence of disability on May 10, 1995, and stopped work on May 11, 1995, as a result of his accepted employment injury.

By decision dated April 3, 1998, the Office denied the claim for recurrence of disability.

On February 12, 1998, the claimant requested reconsideration of the July 18, 1995 decision. Following a merit review of the record, the Office issued a decision dated April 15, 1998, modifying the July 18, 1995 decision to find that the claimant's entitlement to compensation was denied under 5 U.S.C. § 8106(c)(2) because he abandoned the job.

The Board noted that the April 15, 1998 decision effectively superceded the earlier denials of the claim for continuing compensation and claim for recurrence of disability by changing the basis for denial to neglect of suitable work. The Board found that the Office improperly terminated compensation benefits based on the April 15, 1998 decision.

The Board noted:

> "In this case, the Office failed to provide appellant with the due process protections set forth in *(Maggie L.) Moore* and *(Tobey) Rael.* Although the Office provided due process protections prior to appellant's acceptance of the offered employment on May 1, 1995, those protections did not justify the Office's decision on April 15, 1998 to terminate compensation benefits for subsequent neglect of suitable work. When it invoked 5 U.S.C. § 8106(c)(2), the Office reminded appellant of the penalty provision on January 9, 1998 but failed to notify him that the position in question remained available and that he could still return to the position without penalty. Further, the Office extended no period of time for appellant either to return to the position or to provide reasons for not

returning. The Office's March 7, 1996 notice and opportunity to respond related to the initial acceptance or refusal of the offered employment and afforded no due process protection against the April 15, 1998 termination for neglect."

The Office's decision was, consequently, reversed.

FECA CIRCULAR NO. 03-04

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

The interest rate to be assessed for the prompt payment bills is 4.25 percent for the period of January 1, 2003 through December 31, 2003.

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 2.0 percent for the period of January 1, 2003 through December 31, 2003.

Ordinarily, the rate of interest charged on debts due the government is only changed in January, and is effective for the entire year. However, the rate may be changed in July if there is a difference in the Current Value of Funds (CVF) interest rate of 2.0 percent or more. The rates are reviewed each June, and if the rate has changed another Circular will be published to advise all appropriate personnel of the new rate.

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

DEBORAH B. SANFORD
Director, Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

BCT-FY03.nfo

1/1/03 – 12/31/03	4 1/4%
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

1/1/03 – 12/31/03	2%
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. 03-05 **September 5, 2003**

SUBJECT: SELECTED ECAB DECISIONS FOR OCTOBER – DECEMBER, 2001

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

The subjects addressed include: compensation – entitlement during administrative suspension; emotional conditions – performance of duty – employment factors alleged - investigations; forfeiture – doctrine of *res judicata*; forfeiture of compensation – provisions of 5.U.S.C. 8148(a);

suspension of compensation – provisions of 5 U.S.C. 8148(b).

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 – ENTITLEMENT DURING ADMINISTRATIVE SUSPENSION

Mary Ann Shumaker, Docket No. 01-528, Issued October 1, 2001

The issue in this case was whether the claimant was entitled to compensation after December 2, 1999 during a period of administrative suspension.

The claim was accepted for herniated nucleus pulposus, L5-S1. The claimant returned to work on December 2, 1999 and worked a half day of limited duty with specified work restrictions. However, later that same day, she was suspended without pay pending an investigation due to administrative reasons.

On December 14, 1999, the claimant filed Form CA-7 requesting wage-loss compensation from December 3, 1999 to the present. By decision dated January 24, 2000, the Office denied her compensation claim for the reason that she was no longer totally disabled and could resume full-time, restricted employment.

The Board affirmed the Office's decision finding that the claimant failed to establish that her disability for work after December 2, 1999 was causally related to the accepted work injury of November 16, 1999, reasoning that:

"In this case, the evidence of record does not show that appellant was disabled from work after December 2, 1999 because of her accepted condition of herniated nucleus pulposus at L5-S1. Appellant returned to work for a half day on December 2, 1999 following medical release before filing a claim for wage-loss compensation. The record indicates that appellant was suspended without pay pending investigation of her activity while in continuation of pay status and notwithstanding her administrative suspension beginning December 2, 1999 limited-duty work conforming to her medical restrictions was accommodated and remained available to appellant."

The claimant was not allowed to use her employment injury to shield her from wage loss that resulted from an unrelated matter. The Board's ruling emphasizes the fact that entitlement to compensation arises from injury-related disability.

EMOTIONAL CONDITIONS – PERFORMANCE OF DUTY – EMPLOYMENT FACTORS ALLEGED – INVESTIGATIONS

Gail L. Friedl, Docket No. 00-2600, Issued October 4, 2001

The issue in this case was whether the claimant established that she developed an emotional condition due to factors of her federal employment.

The claimant attributed her emotional condition to her participation in an investigation of her supervisor by postal inspectors.

The Office issued a decision which denied the claim for the reason that the evidence of record failed to establish a compensable factor of employment.

The Board upheld the Office's decision, finding that the claimant failed to establish that she developed an emotional condition due to factors of her employment. With respect to the issue of participation in an investigation, the Board explained:

"The record establishes that appellant took part in the investigation; however, the postal inspector indicated that appellant volunteered to supply information regarding wrongdoing by her supervisor after a request for a report. There is no evidence that appellant was required to participate in the investigation such that it became a specially assigned task. Generally, investigations are related to the performance of an administrative function of the employer and are not compensable factors of employment unless (the investigations) are affirmative evidence that the employer either erred or acted abusively in the administration of the matter. Appellant has not established any error by the employing establishment in conducting the investigation. Therefore this is not a compensable factor of employment as there was no evidence of error or abuse on the part of the employing establishment in the conduct of the investigation."

A key point to take from this decision is that the claimant's participation in the investigation was voluntary, and as such, cannot be considered to have become a specially assigned task.

FORFEITURE – DOCTRINE OF *RES JUDICATA*

Robert Ringo, Docket No. 99-2281, Issued December 11, 2001

The issue of interest in this case was whether the overpayment of compensation was "extinguished" by a February 18, 1995 settlement of a lawsuit brought by the employing agency against the claimant under the Program Fraud Civil Remedies Act (PFCRA).

The Office had declared an overpayment in the amount of $80,320.61, finding that the claimant forfeited his right to compensation from March 7, 1988 to August 4, 1992 as a result of failing to properly notify the Office of earnings.

In a December 1994 complaint, the employing agency accused the claimant of four counts of filing a false affidavit of earnings and employment in violation of the PFCRA. In a February 18, 1995 settlement agreement between himself and the employing agency, the claimant agreed to pay the agency $5,000 pertaining to Count 1. Counts 2 through 4 were subsequently dismissed.

By decision dated August 14, 1995, an Office hearing representative determined that the claimant was liable for repayment of the $80,320.61, with interest. The hearing representative further found that the claimant had knowingly failed to report his employment activities from November 1987 to May 1992 and that those duties fairly and reasonably represented his wage-earning capacity.

The claimant filed an appeal before ECAB contending that the overpayment was "extinguished" under the doctrine of *res judicata* under the PFCRA settlement and dismissal.

The Board affirmed the Office's decision finding that the overpayment of compensation was not "extinguished" under the doctrine of *res judicata*, explaining:

"The common-law doctrine of *res judicata*, also known as claim preclusion, may apply to adjudicatory determinations of administrative bodies that have attained finality. In *Leopoldo Sandoval* [42 ECAB 282, 1990], the Board stated that a final judgment on the merits bars further claims by parties or their privies based on the same cause of action. The judgment puts an end to the cause of action, which cannot again be brought into litigation between the parties upon any ground whatever, absent fraud or some other factor invalidating the judgment. The doctrine of *res judicata* seeks to 'avoid multiple suits on identical entitlements or obligations between the same parties, accompanied, as they would be, by the redetermination of identical issues of duty and breach. A later administrative proceeding would be precluded by *res judicata* in the same circumstances as would a second court proceeding.'

In this case, the February 18, 1995 settlement agreement was between appellant and the employing establishment. The Office was not involved in the settlement in any way and, therefore, cannot be considered a party or privy to that action. Thus, there is no identity of parties. Further, the February 18, 1995 agreement was entered into pursuant to the PFCRA and

not the Act. Thus, there is no identity of duty or breach of duty and *res judicata* cannot apply."

As the Board noted, the Office was not party to the original settlement agreement, nor did the settlement involve the FECA, as such, the doctrine of *res judicata* is not applicable.

FORFEITURE OF COMPENSATION – PROVISIONS OF 5 U.S.C. 8148(a)

Lawrence M. Morris, Docket No. 99-1250, Issued December 12, 2001

The issue in this case was whether the Office properly determined that the claimant had forfeited his right to compensation under the provisions of 5 U.S.C. § 8148(a).

Public Law No. 103-333, enacted on September 30, 1994, amended the FECA by adding section 8148, which provides for forfeiture of compensation benefits by an individual convicted of fraud with respect to receipt of compensation, and prohibits the payment of compensation benefits to an individual while incarcerated pursuant to a felony conviction.

On February 17, 1995 the claimant signed a plea agreement in which he pleaded guilty to a violation of 18 U.S.C. § 1920. The agreement specified that this was a misdemeanor offense. The agreement was accepted and signed by the District Court judge on February 17, 1995.

The claimant argued that section 8148(a) may only be applied to a felony violation of 18 U.S.C. § 1920, and was, therefore, not applicable to the claimant. He further argued that because section 8148 does not specifically state that the violation must be a misdemeanor or a felony, the Board should look to the heading of section 8148 for guidance.

The Board was not persuaded by this argument stating, "There is no ambiguity in these words [section 8148(a)] that would require guidance from language outside section 8148(a) and there is no justification for the use of general heading to restrict the scope of section 8148(a)."

The Board affirmed the Office's decision finding that "the conviction for a misdemeanor violation of 18 U.S.C. § 1920 requires a forfeiture of compensation pursuant to 5 U.S.C. § 8148(a). The date the guilty plea was accepted in this case is February 17, 1995, and therefore, appellant forfeits entitlement to compensation after that date."

SUSPENSION OF COMPENSATION - PROVISIONS OF 5 U.S.C. 8148(b)

Ralph C. Spivey, Docket No. 01-263, Issued December 4, 2001

The issue of interest in this decision was whether an overpayment occurred when the claimant received disability compensation while he was incarcerated.

The claimant was imprisoned for a period of 30 days for operating a motor vehicle after his license had been suspended pursuant to a conviction for driving under the influence, in violation of section 18.2-272 of the Code of Virginia. The Office declared an overpayment in the amount of $827.29 for the period during which the claimant was incarcerated.

The Board noted that the Code of Virginia section 18.2-272 titled "Driving after forfeiture of license" provided, "If any person so convicted shall, during the time for which he is deprived of his right so to do, drive or operate any motor vehicle, engine or train in this Commonwealth, he shall be guilty of a Class 1 misdemeanor."

The Board also noted that Section 8148(b)(1) of the Federal Employees' Compensation Act provides as follows:

> "Notwithstanding any other provision of this chapter (except as provided under paragraph (3)), no benefits under this subchapter or subchapter III of this chapter shall be paid or provided to any individual during any period during which such individual is confined in a jail, prison or other penal institution or correctional facility, pursuant to that individual's conviction of an offense that constituted a felony under applicable law."

Consequently, the Board found that the evidence of record failed to establish that the offense for which the claimant was convicted "constituted a felony under applicable law," as is required under the provisions of 5 U.S.C. 8148(b).

As the record did not establish that the incarceration was as a result of a felony conviction, the Board reversed the Office's decision with respect to the fact of overpayment.

FECA CIRCULAR NO. 03-07

SUBJECT: Forms – Appeal Rights

Revised appeal rights have been attached to all decisions and letters requiring appeal rights currently found in the National Letter Generation System (LGS). The claimant's rights to appeal have not changed, but the format is different.

The new appeal rights include a check-list. The claimant is instructed to detach, fill out, and mail the checklist to the appropriate address, if they wish to appeal the decision. The revised appeal rights are easier to understand and more user-friendly. They should also assist in the proper identification of reconsideration requests upon receipt.

Effective immediately, for any decisions that are not generated through the National LGS, the claims examiner **must attach a copy of the revised appeal rights.** Full appeal rights are available as a stand-alone document in the National LGS. All earlier versions are obsolete and should be replaced with the appropriate revision.

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. 03-08 **June 23, 2003**

SUBJECT: FORMS CORRESPONDENCE - DELETION OF LETTERS

In preparation for the new "Correspondence Library" that will be implemented with iFECS, the following 71 letters have been identified for deletion from Forms Correspondence. The letters noted are either obsolete or there are now letters in the National LGS that serve the same purpose.

CA-180 - in LGS
CA-181 - in LGS
CA-1006 - obsolete
CA-1008 - in LGS
CA-1011 - in LGS
CA-1020 - in LGS
CA-1021 - obsolete
CA-1024 - obsolete
CA-1025 – obsolete
CA-1037 - obsolete
CA-1038 - in LGS
CA-1041 - obsolete
CA-1042 - in LGS
CA-1047 - in LGS
CA-1048 - in LGS
CA-1049 - in LGS
CA-1050 - in LGS
CA-1058 - obsolete
CA-1059 - in LGS
CA-1063 - in LGS
CA-1064 - in LGS
CA-1074 - in LGS
CA-1079 - obsolete

CA-1081 - in LGS
CA-1082 - in LGS
CA-1086 - in LGS
CA-1090 - in LGS
CA-1123 - obsolete
CA-1207 - in LGS
CA-1208 - in LGS
CA-1302 - in LGS
CA-1303 - in LGS
CA-1306 - obsolete
CA-1309 - in LGS
CA-1311 – obsolete
CA-1312 - obsolete
CA-1314 - obsolete
CA-1316 - in LGS
CA-1328 - in LGS
CA-1330 - obsolete
CA-1336 - in LGS
CA-1342 - obsolete
CA-1343 – obsolete
CA-1653 - obsolete
CA-1655 - in LGS
CA-1656 - in LGS
CA-1657 - in LGS
CA-2201 - in LGS
CA-2202 - in LGS
CA-2209 - obsolete
CA-2211 - obsolete
CA-2212 - obsolete
CA-2217 - in LGS
CA-2218 - obsolete
CA-2223 - in LGS
CA-2224 - in LGS
CA-2226 - in LGS
CA-6001 - in LGS
CA-6004 - in LGS
CA-6005 - in LGS
CA-6007 - in LGS
CA-6018 - obsolete
CA-9000 - obsolete
CA-9001 - in LGS
CA-9002 - in LGS
CA-9003 - in LGS

CA-9006 - in LGS
CA-9007 - in LGS
CA-9008 - in LGS
CA-9800 - obsolete
CA-9995 - obsolete

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. 03-09 **September 23, 2003**

SUBJECT: SELECTED ECAB DECISIONS FOR JULY – SEPTEMBER, 2002

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

The subjects addressed include: medical opinions – impartial medical examinations – clarification of impartial reports; medical opinions – impartial medical examinations – impartiality – close association of medical practices; medical opinion – impartial medical examinations – impartiality – IME who performs fitness-for-duty exams; medical opinions – impartial medical examinations – scheduling appointments.

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)

BCT-FY03.nfo

MEDICAL OPINIONS – IMPARTIAL MEDICAL EXAMINATIONS -CLARIFICATION OF IMPARTIAL REPORTS

Frank J. Argentieri, Docket No. 02-594, Issued September 3, 2002

The issue in this case was whether the Office properly reduced the claimant's compensation benefits on the basis of an impartial medical specialist's report.

The case was accepted in September of 1990 for a lumbosacral sprain and strain. The claimant was able to return to half-time, light-duty in July of 1991; however, he again stopped all work on July 30, 1991, due to a recurrence of injury. On March 20, 1998, the claimant was referred for a second opinion examination with a board-certified orthopedic surgeon. The referral physician opined that the claimant had no residuals of his 1990 work-related condition, but remained partially disabled due to prior spine surgery and resultant degenerative disc disease. He also stated that the claimant could perform full-time, light-duty work with restrictions.

In a report dated May 11, 1999, the claimant's treating orthopedic surgeon stated that the claimant's 1990 employment injury had aggravated the underlying degenerative changes of his spine, and that he was only capable of working four hours per day with restrictions. The Office determined that a conflict of medical opinion existed concerning the claimant's ability to perform work, so he was referred to Dr. Parviz Kambin, a Board-certified orthopedic surgeon, for an impartial medical examination.

In his report of May 30, 2000, Dr. Kambin stated that because the claimant "has not been able to work for nine years, it is my opinion that his present disability will remain permanent." However, Dr. Kambin also stated that "sedentary type of work is within his capability, [although] I am doubtful that he will accept or sustain this type of occupation."

The Office subsequently submitted Dr. Kambin's report to an Office medical adviser, who used it as the basis for completing a work capacity evaluation form dated June 15, 2000. The Office medical adviser opined that the claimant could work eight hours a day, with specific physical restrictions. An Office rehabilitation counselor subsequently identified the job of Dispatcher as within the claimant's physical limitations and reasonably available to him. In a notice of proposed reduction of compensation dated July 9, 2001, the Office determined that Dr. Kambin's opinion carried the weight of the medical evidence and that the claimant could perform the sedentary position of Dispatcher. The Office also determined that the claimant already possessed the experience to perform the identified position, and that the job remained reasonably available to him. In a decision dated August 27, 2001, the Office reduced the claimant's compensation on the grounds that the position of Dispatcher fairly and reasonably represented his wage-earning capacity.

The Board overturned the Office's decision, noting:

"In the present case, the Office selected Dr. Kambin as an impartial specialist to resolve

the conflict in the medical evidence on whether appellant could return to some form of work. The Office cited his May 30, 2000 report as a basis for its decision to reduce appellant's compensation based on his ability to earn wages as a full-time dispatcher. Dr. Kambin's report, however, failed to establish that appellant actually had the physical capability to perform his job, and the Office asked an Office medical adviser, rather that Dr. Kambin himself, to elaborate on appellant's physical capabilities.

The August 27, 2001 decision of the Office of Workers' Compensation Programs is hereby reversed."

In order to resolve a conflict of medical opinion, the Office must rely solely on the well-reasoned, unequivocal report of the impartial examiner.

MEDICAL OPINIONS – IMPARTIAL MEDICAL EXAMINATIONS – IMPARTIALITY – CLOSE ASSOCIATION OF MEDICAL PRACTICES

Ronald Santos, Docket No. 02-624, Issued August 19, 2002

The issue in this case was whether the close association of the medical practices of the second opinion and impartial referral physicians created an appearance of impropriety.

The Office terminated the claimant's compensation benefits on the basis of the March 31, 1999 second opinion report of Dr. James McLennan, who found that the claimant displayed no objective evidence of a neurological or orthopedic condition. The claimant disagreed with the Office's decision and requested a hearing.

The Office hearing representative reversed the termination decision, finding that a conflict in the medical evidence existed between Dr. McLennan and the claimant's treating neurologist, Dr. Eugene Russo. The Office subsequently referred the claimant to Dr. Michael Olin for an impartial medical examination. In his report of December 13, 2000, Dr. Olin opined that the claimant was no longer disabled. On the basis of Dr. Olin's report, the Office again terminated the claimant's compensation benefits by decision dated April 2, 2001. As the claimant disagreed with the Office's decision, he again requested a hearing.

At the hearing, the claimant argued that the Office had not met its burden of proof because Dr. Olin was associated with Dr. McLennan. In support of his argument, the claimant testified that Drs. Olin and McLennan have the same address, their names appear together on the door, they share a waiting room and the same support personnel, and both the second opinion and impartial examinations took place in the same room. In a decision dated December 20, 2001, the Office hearing representative found that the weight of the evidence rested with Dr. Olin and affirmed the termination of compensation benefits.

The Board reversed the Office's decision, with the following discussion:

> "A physician serving as an impartial medical specialist should be one who is wholly free to make a completely independent evaluation and judgment, untrammeled by a conclusion rendered on a prior examination. An opinion of an associate who has already rendered an opinion on the claim cannot be considered completely independent and, therefore, his report cannot be used by the Office to resolve the conflict in the medical evidence. The Board has held that a physician selected as an impartial medical specialist cannot be considered completely independent when an associate has previously served as an Office referral physician in the case.
>
> The importance of safeguarding the independence of impartial medical specialists is also recognized in the Office's procedures. Under the Office's procedures, 'physicians previously connected with the claim or the claimant or physicians in partnership with those already so connected' may not be used as impartial specialists.
>
> In the present case, Dr. Olin shared the same address, suite number, waiting area and examination room as Dr. McLennan, whose opinion was part of the conflict. While there is no evidence in the record to indicate that the two doctors were in a medical partnership there exists an appearance of impropriety due to the close association of the medical practices of Dr. Olin with Dr. McLennan.
>
> Accordingly, the Board finds that Dr. Olin cannot serve as an impartial medical specialist in this case and his report does not resolve the conflict in the medical evidence. Since it is the Office's burden to terminate appellant's compensation, the Board finds the Office has not met its burden of proof in this case."

It should be noted that it is incumbent upon the Office to determine and maintain the appearance of impartiality of any physician selected to serve as an impartial medical examiner.

MEDICAL OPINIONS – IMPARTIAL MEDICAL EXAMINATIONS – IMPARTIALITY – IME WHO PERFORMS FITNESS-FOR-DUTY EXAMS

Steve A. Williams, Docket No. 02-784, Issued August 27, 2002

The issue of interest in this case was whether performance of regular fitness-for-duty exams by the impartial medical examiner for the claimant's employing agency undermined his appearance of impartiality.

In the Steve A. Williams case, the Office determined that a conflict existed between the claimant's treating physician, Dr. J. Davis Pitcher, Jr., and the second opinion referral physician Dr. Thomas Miskovsky, with regard to whether the claimant had continuing, injury-related residuals. To resolve the conflict, the Office referred the claimant to Dr. Richard McCollum for

an impartial medical examination. On the basis of Dr. McCollum's July 17, 1998 report, the Office terminated the claimant's compensation benefits for the reason that his employment-related residuals had ceased. The claimant disagreed with the Office's decision and requested a hearing.

By decision dated January 13, 1999, the Office hearing representative found that Dr. McCollum's July 17, 1998 report was insufficient to resolve the conflict in the medical evidence. The hearing representative directed the Office to obtain a supplemental report from Dr. McCollum to determine whether the claimant's work-related residuals had ceased and whether his April 23, 1998 surgery was employment-related. On the basis of Dr. McCollum's supplemental report dated February 9, 1999, the Office denied authorization of the surgery and terminated the claimant's wage-loss and medical benefits by decision dated April 16, 1999. As the claimant disagreed with the Office's decision, he again requested a hearing.

By decision dated March 21, 2000, the Office hearing representative set aside the prior decision, and directed the Office to further develop the record on whether Dr. McCollum was performing duties as an Office medical advisor at the time of his supplemental report—which would make him ineligible to serve as an impartial medical specialist.

In a decision dated June 20, 2000, the Office again denied authorization of the claimant's prior surgery and terminated his compensation benefits on the basis that all injury-related residuals had ceased by April 16, 1999. In a decision dated February 23, 2001, an Office hearing representative affirmed the Office's decision.

The Board reversed this decision, noting:

> "The Board has long recognized the importance of the impartiality of the physician selected as an impartial medical specialist. In selecting an impartial medical specialist, the physician so designated should be one who is wholly free to make a completely independent evaluation and judgment. A physician performing fitness-for-duty examinations for the employing establishment may undermine the appearance of impartiality and disqualify the physician from serving as an impartial medical specialist. The Office's Procedure Manual acknowledges that medical evidence must be excluded when 'the physician selected for referee examination is regularly involved in performing fitness-for-duty examinations for the claimant's employing establishment.'
>
> The Office hearing representative found that Dr. McCollum did not demonstrate any bias in the case, noting his unequivocal opinions in both the July 17, 1998 and February 9, 1999 reports. The issue, with respect to Dr. McCollum's ability to serve as an impartial specialist, cannot be resolved by reference to the content of the reports submitted. Since the Office relied on the February 9, 1999 report, the issue is whether at that time Dr. McCollum was 'regularly involved' in fitness-for-duty examinations or otherwise had an association with the employing establishment that undermined the appearance of impartiality.

A very limited involvement with the employing establishment may not disqualify a physician from serving as an impartial medical specialist.

The record in this case, indicates that Dr. McCollum performed 13 examinations, at least three of which were fitness-for-duty examinations, in a 4-month period preceding the February 9, 1999 report. This clearly suggests that he was regularly performing examinations for the employing establishment. Such an association with the employing establishment does undermine the appearance of impartiality that is vital to 5 U.S.C. § 8123(a). Accordingly, the Board finds that Dr. McCollum's February 9, 1999 report must be excluded and cannot resolve the conflict in the medical evidence. The Office must select another impartial medical specialist to resolve the medical issues presented."

MEDICAL OPINIONS – IMPARTIAL MEDICAL EXAMINATIONS - SCHEDULING APPOINTMENTS

Leonard R. Popham, Docket No. 01-1624, Issued August 9, 2002

The Board found that the Office's suspension of the claimant's compensation for his refusal to undergo an impartial medical examination was improper.

In order to determine the nature and extent of the claimant's work-related conditions, the Office referred him to a Board-certified orthopedic surgeon who opined that the claimant did not suffer from active lumbar, thoracic, or cervical strains. However, he indicated that due to functional overlay and chronic pain syndrome "clouding his ability to work," the claimant could not return to his date-of-injury position. Nonetheless, the second opinion physician also opined that the claimant could return to sedentary or light-duty work for four hours per day, while slowly progressing to an eight-hour day. On the basis of this report, the Office determined that a conflict of medical opinion existed in the claimant's case.

To resolve the conflict, the Office referred the claimant to another Board-certified orthopedic surgeon for an impartial medical examination. The June 2, 2000 referral letter advised the claimant of the date of the examination and that, under section 8123(d) of the FECA, an employee's right to compensation is subject to suspension if the employee refuses to submit or obstructs a medical examination. When the claimant failed to appear for two scheduled examinations, the Office subsequently issued a notice of proposed suspension of compensation. The Office advised the claimant that he had 14 days to explain why he failed to keep the appointment, and advised him that if he failed to respond, or if his reasons for failing to keep the appointment were found to be unacceptable, then his entitlement to compensation would be suspended until he agreed to submit to the examination.

The claimant responded, by letter dated July 21, 2000, that he had been visiting his father in the surgical intensive care unit at the time of the July 11, 2000 appointment. In a letter dated August 7, 2000, the Office informed the appellant that he could reschedule his appointment with Dr.

Arredondo at either of two locations. The Office afforded the claimant an additional 14 days within which to respond. The Office did not receive a response within the allotted time. By decision dated August 28, 2000, the Office suspended the claimant's right to compensation effective September 10, 2000, for the reason that he refused to attend a medical examination as instructed.

The Board found that the Office acted improperly when it suspended the claimant's compensation, explaining:

> "Pursuant to the Federal (FECA) Procedure Manual, Part 3 -- Medical Examinations, Chapter 3.500.3 (April 1993), after contacting the physician and setting the date and time of the appointment, the Office must notify the claimant in writing as to the name and address of the physician to whom he or she is being referred as well as the date and time of the appointment. In this case, however, no date or time for examination by the impartial specialist was set at the time of the suspension of compensation. Appellant's July 21, 2000 letter explained that he had missed the July 11, 2000 appointment to attend to his father. Thereafter, the Office advised appellant to reschedule the examination rather than contacting the physician's office to set a new time and date for examination. Thus, the Office acted improperly in suspending the appellant's compensation."

The key point to take from this decision is that it is the Office's responsibility to schedule second opinion (through the Office contractor) and impartial examinations, and then to duly notify the claimant of the time, date, and location of the scheduled appointment.

FECA TRANSMITTALS (FT)--INDEX

FT 03-07 Revision to Chapter 2-1300, Lump-Sum Payments, Part 2 - Claims, Federal (FECA) Procedure Manual

FT 03-09 Revision to Chapter 2-11, Feca Third Party Subrogation Guidelines, Part 2 - Claims, Federal (FECA) Procedure Manual (Formerly Chapter 2-1100, Subrogation and Other Remedies)

FECA TRANSMITTALS (FT)--TEXT

FECA TRANSMITTAL NO. 03-01 June 30, 2003

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

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraphs 2 and 4 are updated to incorporate FECA Bulletin No. 01-05, providing the effective date for use of the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment. Exhibit 4 of this chapter is replaced, incorporating the attachment to FECA Bulletin 01-05 which provides a discussion regarding the use of the Fifth Edition of the AMA Guides.

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, 1-4	3	3-0700	i,1-4
Exhibit 4 (pages 1 to 4)			Exhibit 4 (pages 1 to 5)		
Exhibit 4 (pages 1 to 4)			Exhibit 4 (pages 1 to 5)		

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

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

FECA TRANSMITTAL NO. 03-02 **September 9, 2003**

RELEASE - REVISION TO CHAPTER 2-1500, RECURRENCES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 5 of Chapter 2-1500, Recurrence of Medical Condition, has been updated to include new language. Section c. of this paragraph notes that claims for recurrence following an approved destructive surgery do not require significant development. Paragraph 7.a.(4) on Recurrent Disability for Work After 90 Days from Return to Duty has been modified to clarify the current procedures if withdrawal of light duty occurs when no previous LWEC determination has been made. Paragraph 7.a.(5) has been added to describe CE actions upon withdrawal of light duty with an existing LWEC determination (including "0" LWEC) in place.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1500	i 3-10	2	2-1500	i 3-10

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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. 03-03 **January 2, 2003**

RELEASE - REVISION TO CHAPTER 2-0800 DEVELOPMENT OF CLAIMS, PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-0800 is updated in paragraphs 4 on Forms and 5 on Processing Claims to incorporate FECA Bulletin 96-10. This update removes the procedural requirements for completing items 20-23 of Form CA-800. It also removes the reference to Form CA-1009 being separate from form letter CA-1008. The reference to sending the case file to the file room or other location pending adjudication has also been removed.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages 2
2	2-0800-4	5 to 8	2	2-0800-4	5 to 8

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FECA TRANSMITTAL NO. 03-04 **May 9, 2003**

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

EXPLANATION OF MATERIAL TRANSMITTED:

In Chapter 2-1700, paragraph 8 has been revised to include additional guidance on handling the claims of contract observers on vessels. Subparagraph d. addresses other considerations specifically pertaining to determination of pay.

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, 17	2	2-1700	i, 17-18

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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. 03-05 **May 23, 2003**

RELEASE - REVISION TO CHAPTER 3-0500, MEDICAL EXAMINATIONS, PART 3 -

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MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 3-0500, at paragraph 4.b.(1), is modified to note that the services of all qualified Board-certified specialists, including those certified by the AOA (American Osteopathic Association) and the ABMS (American Board of Medical Specialties) of the American Medical Association, are to be used to obtain referee medical examinations.

Paragraph 7.a. has also been revised to clarify the point that OWCP may use osteopathic physicians certified by the AOA as well as medical doctors certified by the ABMS to perform referee medical examinations. It also points out that medical referral groups are now used throughout OWCP to arrange for second opinion examinations.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
3	3-0500	i, 5-6, 13-16	3	3-0500	i, 5-6 13-16

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RELEASE - REVISION TO CHAPTER 2-0812, PERIODIC REVIEW OF DISABILITY CASES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 5, on PRMS codes has been inserted into Chapter 2-812. This has resulted in all the succeeding paragraphs being re-numbered, e.g., the previous paragraph 5 is now paragraph 6. The new paragraph 5 incorporates the PRMS coding referenced in FECA Bulletins No. 95-15 and 99-03 into the Procedure Manual. Three new codes are added, i.e. (R0), (R4), and (T7).

Paragraph 10 of Chapter 2-0812 has been updated to include revised procedures for issuing CA-1036s, CA-935s, and SSA-581s, incorporating FECA Bulletin No. 01-04.

Paragraph 12 of Chapter 2-0812 has been updated to include new instructions for completing form RI 20-8 from the Office of Personnel Management. The section has also been updated to clarify when the claims examiner should make deductions for optional life insurance.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0812	i,3-22 Exhibits 2,3	2	2-0812	i,3-24 Exhibit 2

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FECA TRANSMITTAL NO. 03-07 **July 15, 2003**

RELEASE - REVISION TO CHAPTER 2-1300, LUMP-SUM PAYMENTS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 4 has been added to Chapter 2-1300 to explain how CEs will use the new Lump-Sum Schedule Award Calculator program to calulate future lump-sum award payments. The paragraph entitled "Requests for Reconsideration of Lump-Sum Decisions" has been renumbered as paragraph 5. In addition, revisions have been made throughout the Chapter to reflect the correct C.F.R. and FECA citations. Finally, exhibit 5 was removed, a revised exhibit 6 became a part of exhibit 3, and exhibits 1-4 were revised to reflect the correct C.F.R. citations and the new appeal rights.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1300	i, 1-5 Exs. 1-6	2	2-1300	i, 1-6 Exs. 1-4

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FECA TRANSMITTAL NO. 03-09 **September 24, 2003**

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RELEASE - REVISION TO CHAPTER 2-1100, FECA THIRD PARTY SUBROGATION GUIDELINES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL (FORMERLY CHAPTER 2-1100, SUBROGATION AND OTHER REMEDIES)

EXPLANATION OF MATERIAL TRANSMITTED:

For the purposes of clarity and ensuring that subrogation procedures are uniform across OWCP and the Regional Solicitor's Offices of SOL (RSOL), Chapter 2-1100 has been rewritten in its entirety. In addition, the new chapter incorporates the substantial regulatory changes that went into effect in 1999. Finally, the chapter has been renamed FECA Third Party Subrogation Guidelines to more accurately reflect its contents.

DEBORAH B. SANFORD
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages				Insert New Pages	
Part	Chapter	Pages		Part	Chapter
2	2-1100	i, 1-23, Exhs. 1-3		2	2-1100
		i, 1-38			

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OWCP BULLETINS (OB)--INDEX

OWCP BULLETINS (OB)--TEXT

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OWCP CIRCULARS (OC)--INDEX

OWCP CIRCULARS (OC)--TEXT

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%. The 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. The initial CPI figures (2.7% and 3.4%) were originally kept in the system for consistency, rather than adjusting to the corrected BLS figures. However, in order to remain statistically correct, the figures have been adjusted this year to reflect the corrected BLS figures.

2 (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%. The 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. The initial CPI figures (2.7% and 3.4%) were originally kept in the system for consistency, rather than adjusting to the corrected BLS figures. However, in order to remain statistically correct, the figures have been adjusted this year to reflect the corrected BLS figures.