BCT-FY09

This infobase contains a numerical index of all FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 2007, as well as the text of these issuances.

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

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FECA BULLETIN

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FECA BULLETIN--Text

FECA BULLETIN NO. 09-01

Issue Date: February 15, 2009

Expiration Date: January 1, 2010

Subject: Compensation Pay: Compensation Rate Changes Effective January 2009.

Background: On December 18, 2008, the President signed Executive Order 13483 implementing a salary increase of 2.90 percent in the General Schedule basic pay. The applicability under 5 U.S.C. 8112 only includes the 2.90 percent increase in the basic General Schedule. Any additional increase for locality-based pay is excluded. The adjustment became effective at the start of the first full pay period after January 1, 2009.

Purpose: To inform the appropriate personnel of the increased minimum/maximum rates of compensation 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, 2009. Thus, for daily roll supplemental payments January 10, 2009 is the specific effective date of the increase. The effective date for the increase of periodic and death roll payments will be January 18, 2009. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, step 10, which is now $127,604 per annum. The basis for the minimum compensation rate is the salary of a GS-2, Step 1 which is $19,721 per annum.

The minimum increase specified in this Bulletin is applicable to employees of the U.S. Postal Service.

The effect on 5 U.S.C. 8112 is to increase the payment of compensation for disability claims to:

Effective January 10, 2009	Minimum	Maximum
Weekly	$284.44	$1,840.44
Daily (5-day week)	56.89	360.09
Effective January 18, 2009	**Minimum**	**Maximum**
28-Day Cycle	$1,137.75	$7,361.77

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 18, 2009	Minimum	Maximum
Monthly	$1,643.42	$7,975.25

Applicability: Appropriate National and District Office personnel

Reference: Memorandum for Executive Heads of Departments and Agencies dated December 18, 2008; and the attachment for the 2009 General Schedule.

Action: The Integrated Federal Employees' Compensation System (iFECS) will update the periodic disability and death payrolls. It should be noted that this adjustment process re-calculates EVERY compensation record from its very beginning to current date. Thus, it may be that minor changes in the gross compensation are noted; this is not necessarily incorrect.

Any cases keyed as "Gross Overrides without CPI" in iFECS will not have a supplemental record or make a separate calculation of additional entitlement. Thus, these gross override cases must be reviewed to determine if adjustments are necessary. If adjustment is necessary, a manual calculation will be required and the case record documented. A notice should be sent to the payee by the District Office, detailing the change in the rate of compensation. All cases keyed as "Gross Overrides with CPI" will be adjusted in the usual manner.

1. Adjustments Dates.

   a. As the effective date of the adjustment was January 18, 2009 for the periodic disability and death rolls, there was no supplemental payroll needed. The February 14, 2009 death and disability payments will include any necessary minimum/maximum compensation adjustments.

   b. The new minimum/maximum compensation rates were available in iFECS on February 2, 2009.

2. Adjustment of Daily Roll Payments. The salary adjustments are not retroactive, so 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, 2009. Therefore, it is not necessary to review any of these payments.

   However, if an inquiry is received then verification of the pay rate must be secured from the employing agency, and the necessary adjustment applied.

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

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 09 – 02

Issue Date: March 1, 2009

Expiration Date: February 28, 2010

Subject: Compensation Pay - Consumer Price Index (CPI) Cost-of-Living Adjustments

for March 1, 2009.

Purpose: To furnish information on the CPI adjustment process for March 1, 2009.

The cost of living adjustments granted to a compensation recipient under the FECA are based on the "Consumer Price Index for Urban Wage Earners and Clerical Workers" (CPI-W) figures published by the Bureau of Labor Statistics (BLS). The annual cost of living increase is calculated by comparing the base month from the prior year to the base month of the current year, with the percentage of increase adjusted to the nearest one-tenth of 1 percent, determining the amount of the CPI increase granted to claimants. 5 U.S.C. § 8146a establishes the base month as December.

December 2007 had a CPI-W level of 205.777 per BLS. The CPI-W level for December 2008 was reported as 204.813 by BLS, which is in fact a decrease of 0.5% from the December 2007 level. As a result of this decline in the CPI-W level, there will not be a cost of living increase for FECA recipients in 2009.

1. Despite the lack of an increase, the new base month is December 2008.

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

$ 7,975.25 per month
7,361.77 each four weeks
1,840.44 per week
360.09 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; Bureau of Labor Statistics Consumer Price Index Publication for December 2008 (USDL-09-0035)

Action: Since there is no change this year there is no action required by the National Office Production staff to re-calculate or adjust compensation.

1. 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 to indicate that there will not be an increase in 2009. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966, through March 1, 2009, for reference.

2. Forms.

a. All claimants will be provided a notice with their Benefit Statement, indicating that there will not be a CPI increase this year. The Treasury will include this notice as a "stuffer card" with every Benefit Statement issued for the March 14, 2009 rolls.

b. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification; insurance verification; loan application; etc.), please continue to 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. A 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.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Attachment

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

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

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	03/01/87	0.7%
01/01/68	3.7%	03/01/88	4.5%
12/01/68	4.0%	03/01/89	4.4%
09/01/69	4.4%	03/01/90	4.5%
06/01/70	4.4%	03/01/91	6.1%
03/01/71	4.0%	03/01/92	2.8%
05/01/72	3.9%	03/01/93	2.9%
06/01/73	4.8%	03/01/94	2.5%
01/01/74	5.2%	03/01/94	2.5%
07/01/74	5.3%	03/01/95	2.7%
11/01/74	6.3%	03/01/96	2.5%
06/01/75	4.1%	03/01/97	3.3%
01/01/76	4.4%	03/01/98	1.5%
11/01/76	4.2%	03/01/99	1.6%
07/01/77	4.9%	03/01/00	2.8%
05/01/78	5.3%	03/01/01	3.3%
11/01/78	4.9%	03/01/02	1.3%
05/01/79	5.5%	03/01/03	2.4%
10/01/79	5.6%	03/01/04	1.6%

04/01/80	7.2%	03/01/05	3.4%
09/01/80	4.0%	03/01/06	3.5%
03/01/81	3.6%	03/01/07	2.4%
03/01/82	8.7%	03/01/08	4.3%
03/01/83	3.9%	03/01/09	0.0%
03/01/84	3.3%		
03/01/85	3.5%		
03/01/86	N/A		

Prior to September 7, 1974, 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 September 7, 1974, the new compensation after adding the CPI is rounded to the nearest $1.00 on a monthly basis or the nearest $.25 on a weekly basis ($.25, $.50, $.75, or $1.00).

Prior to 09/07/74	.08-.34 = .23	Eff. 11/01/74	.13-.37 = .25
	.35-.57 = .46		.38-.62 = .50
	.58-.80 = .69		.63-.87 = .75
	.81-.07 = .92		.88-.12 = 1.00

ATTACHMENT TO FECA CIRCULAR NO. 09-02

FECA BULLETIN NO. 09-03

Issue Date: March 15, 2009

Expiration Date: May 1, 2010

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

Background: The schedule award provisions of the Federal Employees' Compensation Act (FECA) at 5 U.S.C. 8107 and its implementing regulations at 20 C.F.R. 10.404 establish the compensation payable to employees sustaining permanent impairment. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables with uniform standards applicable to all claimants. The American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment has been adopted by the Office of Workers' Compensation Programs Division of Federal Employees' Compensation (DFEC) as the appropriate standard for evaluating schedule losses. In January 2008, the AMA published the Sixth Edition of the Guides, noting that the Guides are revised periodically to incorporate current scientific clinical knowledge and judgment. This Edition implements substantial reforms to the methodology of calculating permanent impairment. In accordance with its long established practice, the DFEC is moving forward to the most recent version of the Guides and generally utilizes the Sixth Edition in evaluating permanent impairment under the Guides.

The Sixth Edition substantially revises the evaluation methods used in previous Editions, characterizing the new methodology's objectives as: to be consistent, to enhance relevancy, to promote precision and to standardize the rating process. The AMA describes the Sixth Edition of the Guides as implementing a major paradigm shift in the way impairment evaluations are conducted based on five axioms: (1) Adopting terminology and the conceptual framework of disablement outlined by the World Health Organization's (WHO's) International Classification of Functioning, Disability, and Health (ICF); (2) Becoming more diagnosis-based and basing the diagnoses in evidence; (3) Optimizing rater reliability through simplicity, ease of application and following precedent; (4) Rating percentages are functionally based to the fullest extent possible; (5) Stressing conceptual methodological congruity within and between organ rating systems.

The attachment describes the major changes in the Guides applicable to FECA as well as those areas where other criteria apply.

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

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

Action:

1. **EFFECTIVE DATE OF MAY 1, 2009.** All Claims Examiners should begin using the Sixth Edition of the AMA Guides effective May 1, 2009. Correspondence with treating physicians, consultants and second opinion specialists should reflect the use of the new Edition for decisions issued after May 1, 2009, and form letters that refer to the AMA Guides are revised to reflect this change. All schedule award decisions issued on or after May 1, 2009, should be based on the Sixth Edition of the A.M.A. Guides with the exceptions (such as statutory criteria) as noted.

2. **RECALCULATIONS RESULTING FROM HEARINGS, REVIEW OF THE WRITTEN RECORD OR RECONSIDERATIONS.** Any recalculations of previous awards which result from hearings or reconsideration decisions issued on or after May 1, 2009, should be based on the Sixth Edition of the Guides. However, if the percentage of the award is affirmed but the case is remanded for further development of some other issue, i.e. pay rate, recalculation of the percentage of the award under the Sixth Edition is not required.

3. **REQUESTS FOR INCREASED SCHEDULE AWARD WHERE PRIOR AWARD WAS MADE UNDER AN EARLIER EDITION OF AMA GUIDES** In accordance with DFEC's established practice when moving to an updated version of the AMA Guides, awards made prior to May 1, 2009, are not and should not be recalculated merely because a new Edition of the Guides is in use. A claimant who has received a schedule award calculated under a previous Edition and who claims an increased award, will receive a calculation according to the Sixth Edition for any decision issued on or after May 1, 2009. Should the later calculation result in a percentage impairment lower than the original award (as sometimes occurs), the Claims Examiner or Hearing Representative should make the finding that the claimant has no more than the percentage of impairment originally awarded, that the evidence does not establish an increased impairment and that therefore the Office has no basis for declaring an overpayment.

Disposition: Retain until the indicated expiration date.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

ATTACHMENT 09-03
AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition

The Sixth Edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment differs significantly from previous Editions. There are extensive changes affecting the calculations of schedule awards for FECA claimants. The latest Edition represents both a paradigm shift as well as the continued evolution in creating a uniform and consistent method for measuring impairment. The Sixth Edition of the AMA Guides consists of seventeen chapters, one less than the Fifth Edition. (Two cardiovascular chapters in the Fifth Edition have been consolidated into one chapter in the Sixth.)

The biggest alteration from previous Editions involves the rating of permanent impairment based on a specific diagnosis rather than the extremity or organ system. In previous Editions, an impairment rating may have included multiple diagnoses within an organ or extremity. Under the Sixth Edition most ratings will consider only the diagnosis with the most impact on the rated body region, i.e. digits/hand, wrist, elbow and shoulder are the regions defined for the upper extremity. However, once a rating is established for a specific region, the ratings for various regions within an extremity will be combined, just as in the Fifth Edition. For instance, a rating may be established separately for an entrapment neuropathy at the wrist, another at the elbow and a third rating for a shoulder impingement. Those three ratings would then be combined using the Combined Values Chart to establish the impairment rating for the upper extremity. In the Fifth Edition of the Guides, impairment ratings relied heavily on loss of range of motion and strength in comparison to a paired extremity. The Sixth Edition primarily incorporates these findings only insofar as they relate to the specific diagnosis evaluated.

Key changes affecting the calculation of schedule awards for FECA claimants are highlighted below. Also summarized are circumstances where calculations are done under criteria that vary from the Sixth Edition:

1. **DIAGNOSIS BASED GRID:** The foundation of the new methodology is the diagnosis-based grid used for each organ system and chapter. Evaluators will rate impairment according to the diagnosis representing the source of the most impairment in the given body region. If there is more than one ratable diagnosis in an affected extremity, the rater should combine all regional impairments for a final impairment at the extremity level. This combining of impairment ratings does not represent a change from prior

Editions.

Each diagnosis grid is divided into five classes of impairment severity, ranked from '0' (no impairment) to '4' (very severe). Within each class are five severity grades categorized 'A' through 'E' (default 'C') with corresponding impairment percentages.

Raters distinguish the level of severity using criteria separated into key factors and non-key factors. These criteria consist of: (1) history of clinical presentation; (2) physical findings; (3) clinical studies or objective test results; (4) functional history. In most organ systems or disease processes, clinical history is the key factor which will determine the impairment class. However, physical findings or objective test results may serve as the key factor in select organ system evaluations. The evaluator will adjust the severity grade based on the results of the remaining criteria. For instance, if the claimant has an accepted condition of right shoulder impingement syndrome, the evaluator would use Table 15-5 to locate that diagnosis. The history of clinical presentation (key factor) would be used to determine whether the severity of the condition would be a Class 0 (no impairment) or a Class 1. Tables 15-7, 15-8 and 15-9 would then be consulted to determine where, within Class 1, the impairment would fall based on functional history, physical examination and clinical studies (non-key factors). These adjustments cannot exceed the percentage of impairment within the range specified by the designated class.

2. **MUSCULOSKELETAL:** Musculoskeletal regions in the Sixth Edition of the Guides consist of the upper extremities (Chapter 15), lower extremities (Chapter 16) and the spine and pelvis (Chapter 17). The upper extremity is divided into four separate zones, including digits/hand, wrist, elbow and shoulder. The lower extremity is divided into three zones consisting of foot/ankle, knee and hip. The spine and pelvis is divided into four zones, including cervical, thoracic, lumbar, and the pelvis (consisting of the ilium, ischium, pubis, sacrum and coccyx). Diagnosis classes for the upper and lower extremities are broken into the following categories: Soft tissue, muscle and tendon, ligament, and bone and joint. If impairment percentages are calculated in whole person ratings, they must be adjusted to individual extremity or organ system percentages using conversion charts or rates.

3. **PAIN:** The chapter on impairments due to pain (Chapter 3) has been updated. As with the Fifth Edition, the Sixth Edition allows for a maximum 3% impairment rating for non-specific pain that cannot be attributed to a condition addressed elsewhere in the Guides. However, **in no circumstances should the pain-related impairment developed under Chapter 3 be considered as an add-on to impairment determinations based on the criteria listed in Chapters 4 – 17.** While the Guides permit a presumptive percentage for pain when it is not accompanied by objective findings, if the pain accompanies objective findings, the rating is made using the applicable chapter.

4. **CARPAL TUNNEL:** Entrapment neuropathy of the upper extremities (e.g. carpal tunnel, cubital tunnel, etc.) (Section 15.4f) must be documented with nerve conduction velocity (NCV) testing in order to consider ratable impairment under the section on entrapment neuropathy. If testing was not conducted or does not meet the criteria outlined by the Guides, no ratable entrapment neuropathy impairment may be considered and any impairment must be calculated using a different section. Table 15-23 is used to determine entrapment/compression neuropathy impairments. Additionally, the preoperative electrodiagnostic test should be used in the impairment rating unless postoperative studies were done for a clinical indication of failure to improve with surgery and the postoperative study is clearly worse than the preoperative electrodiagnostic study. When evaluating multiple simultaneous neuropathies, the first (or most impairing) is rated at 100%, the second is rated at 50%, and the third is rated at 0% of the impairment listed in Table

15-23. The impairments are then combined. Multiple simultaneous neuropathies of the same region should occur very rarely.

5. **MAXIMUM MEDICAL IMPROVEMENT:** The Guides stipulate only permanent impairment may be rated, and only after the claimant has reached a point of "maximum medical improvement" (MMI). The Guides do not afford a rating for possible future impairment. Impairment should not be rated permanent until sufficient time has passed for healing and recovery, which may vary substantially depending on the condition and the claimant's profile. The clinical findings must indicate the medical condition has stabilized for the claimant to have reached MMI. This approach is consistent with program history, case law and long established practice. *See Franklin L. Armfield*, 28 ECAB 445 (1977).

In cases where a claimant declines surgical intervention or other therapeutic treatment, an MMI determination may still be reached as long as the physician indicates that the individual is at MMI in lieu of additional treatment. MMI is determined to be a point where no further improvement is anticipated and symptoms are expected to remain stable or managed with palliative care.

6. **BACK CONDITION:** As FECA does not allow a schedule award for impairment of the back (see 5 U.S.C. 8101 (19), a diagnosed injury or medical condition originating in the back or spine may **only** be considered to the extent that it results in permanent impairment of the extremities. There is no separate impairment for radiculopathy unless specified in the regional grid in Chapter 17. Even then, radiculopathy is used as a grade modified rather than defining an impairment class. However, the peripheral nerve impairment charts in the upper and lower extremity chapters may be used. Rating impairment to peripheral nerves in the lower extremities is explained in Section 16.4c and Table 16-12. Likewise, upper extremity peripheral nerve impairment is explained in Section 15.4 and Tables 15-20 and 15-21.

7. Under the Sixth Edition of the Guides, an impairment rating may not be allowed simply because there was a surgical intervention. For instance, Table 16-3 under cruciate or collateral ligament injury specifically states that surgery is not a rating factor. However, impairment based on a total knee replacement is provided in Table 16-3.

8. **SPECIAL DETERMINATIONS AFFECTING USE OF SIXTH EDITION** See FECA PM 3-700.4)

a. **Loss of digits/statutory criteria**. While the percentage of impairment is generally computed in accordance with the AMA Guides, special computations may be required. Loss of more than one digit of a hand or foot should be computed in terms of impairment to the whole hand or foot unless the impairment computed for loss of two or more digits exceeds the percentage for the hand or foot. In such instances, the award should reflect the computation most favorable to the claimant. The FECA itself addresses compensation for loss of more than one phalanx as being the same as loss for the entire digit and loss of the first phalanx is one-half the compensation for loss of the entire digit. See 5 U.S.C. 8107 (15). Calculations of amputation at the wrist or ankle are considered the same as a total loss of that member. See 5 U.S.C. 8107 (16).

b. **Loss of hearing**. There continue to be special requirements for hearing loss testing. Special calculation requirements are contained in Program Memoranda 162. 181 and 217. In accordance with 5 U.S.C. 8107 (19), loss is determined without regard to correction.

c. **Loss of vision**. The percentage of impairment continues to be based on best **uncorrected** vision. See 5 U.S.C. 8107 (19). Loss of binocular vision or for loss of 80 percent or more is the same as for loss of the eye. See 8107 (14).

d. **Loss/loss of function of organs**.

1) Where there is total loss of a single paired organ such as one kidney, lung, breast, testicle, or ovary) the schedule award rating is generally based on loss of one organ rather than loss of function of the pair. Under FECA, it is immaterial for purposes of a schedule award evaluation whether the remaining organ of the pair compensates for the loss.

2) Awards for respiratory impairment are based on the loss of use of both lungs and the impairment percentage is multiplied by twice the award for a single lung. However, for anatomical loss by injury or surgery of an entire lung, the award will be for 100% of one lung. Similarly, for loss of less than an entire lung, the impairment percentage will be based on loss of lung tissue by weight or volume and calculated based on the schedule for a single lung. The claimant is entitled to the higher of the impairment based on anatomical loss vs. loss of use calculation.

4) While the AMA Guides express the impairment of certain organs in terms of the whole person, schedule awards under the FECA are based on the percentage of impairment of the particular organ/schedule member. See FECA PM 3-700-4 (c).

FECA BULLETIN NO. 09-04

Issue Date: April 10, 2008

Expiration Date: December 31, 2009

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

Background: Effective January 1, 2009, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobile (POV) was *reduced* to 55 cents per mile by the General Services Administration (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 disabled Federal Employees' Compensation Act (FECA) beneficiaries traveling to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

Reference: Federal (FECA) Procedure Manual Part 5, Benefit Payments, Chapter 204, Principles of Bill Adjudication and 5 U.S.C. § 8103.

Action: The Central Bill Processing (CBP) facility has updated their system to reflect the new rates. Since there is no action required at the District Office level, the rates are being

provided for informational purposes only.

The following is a list of the historical mileage rates used to reimburse claimant travel expense:

01/01/1995 – 06/06/1996	30.0 cents per mile
06/07/1996 – 09/07/1998	31.0 cents per mile
09/08/1998 – 03/31/1999	32.5 cents per mile
04/01/1999 – 01/13/2000	31.0 cents per mile
01/14/2000 – 01/21/2001	32.5 cents per mile
01/22/2001 – 01/20/2002	34.5 cents per mile
01/21/2002 – 12/31/2002	36.5 cents per mile
01/01/2003 – 12/31/2003	36.0 cents per mile
01/01/2004 – 02/03/2005	37.5 cents per mile
02/04/2005 – 08/31/2005	40.5 cents per mile
09/01/2005 – 12/31/2005	48.5 cents per mile
01/01/2006 – 01/31/2007	44.5 cents per mile
02/01/2007 – 03/18/2008	48.5 cents per mile
03/19/2008 – 07/31/2008	50.5 cents per mile
08/01/2008 – 12/31/2008	58.5 cents per mile
01/01/2009 – Current	55.0 cents per mile

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

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 09-05

Issue Date: August 18, 2009

Expiration Date: August 18, 2010

Subject: United States Postal Service National Reassessment Program Guidance

Background: The United States Postal Service (USPS/Postal Service) has undertaken a National Reassessment Process (NRP) affecting a large number of Federal Employees' Compensation Act (FECA) claimants who are currently working for the Postal Service but not at their date of injury position. Some of these claimants are working at a position for which they have received a loss of wage-earning capacity determination (LWEC), while other claimants working light duty positions have not received an LWEC rating. These employees are being advised that no light duty or little light duty (a few hours a day) is available. While the NRP process was piloted in certain areas serviced by a number of Division of Federal Employees' Compensation (DFEC) district offices including San Francisco and Boston, the USPS NRP is now going beyond the piloting stage to nationwide implementation.

Purpose: This bulletin offers guidance to DFEC offices in an effort to provide consistency in claims handling to address these situations:

1. Where Postal employees who have been working light duty positions are being sent home because they have been advised by the Postal Service that there are No Operationally Necessary Tasks (NONT) for them to perform or there is No Work Available (NWA).
2. Where Postal employees who have been working light duty are being required to report to work and being informed that at that point in time there are only a certain number of hours of Operationally Necessary Tasks available for them to perform.

Postal employees encountering some permutation of these scenarios are completing CA-7 forms and seeking wage loss compensation. While some of the impacted Postal Service employees completing CA-7s have formal LWEC ratings in place, other Postal employees have not received a formal LWEC determination for the light duty they are performing. In some instances where an LWEC rating was issued, the Postal employee, his or her representative, or the Postal Service may contend that the job in question was not a real job and was in fact a "make work," "sheltered" or "odd lot" position for which an LWEC rating should not have been made. Other employees may demonstrate a worsening of their accepted medical condition or submit a claim for a recurrence.

Follow the action items and consult the reference sections for additional guidance.
NOTE: A CE should forward any general inquiries concerning the NRP to DFEC management for referral to the Postal Service and should not provide advice or commentary on the NRP to claimants, particularly concerning any USPS personnel requirement that a USPS employee report to work for a given amount of time.

Action items:

When a CA-7 referencing NRP, NONT or NWA is received, each case must be assessed individually with regard to the following three criteria:

A. whether the medical evidence continues to support ongoing injury related disability;
B. whether the claimant is losing intermittent time or making a claim for total wage loss; and
C. whether a formal LWEC rating is in place.

The course of action varies depending on these three criteria.

In all scenarios:

Review the CA-7 carefully to determine exactly what is being claimed (sick or annual leave, administrative leave, LWOP, etc.), and if it is unclear, request clarification from the agency. Note that no changes have been made to the usual leave buy back procedures, and payment cannot be made for any time in which the claimant was on administrative leave.

Once it has been determined that payment should be made, cases should be reviewed individually to determine whether the claimant is entitled to a recurrent pay rate.

- If the recurrence begins more than six months after the injured employee resumed regular full-time employment, payment may then be made at a recurrent pay rate based on a CA-7. As long as the claimant was working a regular full time job when the light duty was withdrawn, the claimant would be entitled to a recurrent pay rate. A full duty return to work is not required; however, if the claimant did not return to regular full-time employment (for example, an individual who is receiving an LWEC based on working four hours a day, 20 hours per week), a recurrent pay rate would not be appropriate. See Reference on recurrent pay rates.
- Note that if a formal LWEC is modified because the original position was determined to be "make work," "sheltered" or "odd lot," the claimant would not be entitled to a recurrent pay rate since the work was by virtue of this finding not "regular" work.

If a claimant is in receipt of a Schedule Award, and a determination has been made to pay the claim, the award should be interrupted so that the claimant can be placed on the periodic roll for temporary total disability or intermittent payments can be made, whichever is applicable.

I. Claims for TOTAL DISABILITY

A. LWEC decision HAS been issued -

If a formal LWEC decision has been issued, the CE must develop the evidence to determine whether a modification of that LWEC is appropriate.

1. All Postal Service cases where CA-7s are received that involve LWEC ratings based on actual positions should be reviewed to confirm that the file contains evidence that the LWEC rating was based on an actual bona fide position. This evidence may include a job offer, an SF 50, a classified position, a formal Position Description or other documentary evidence of file. If it is determined that the LWEC rating was without any factual or legal basis at the time it was issued, the file should be properly documented and the LWEC rating should be formally modified. The CE should then proceed to the action items for cases without LWEC decisions in the file.
2. The CE should review the file to determine whether any medical benefits have been paid in the case and whether a current medical report is on file that supports work-related disability and establishes that the current need for limited duty or medical treatment is a result of injury related residuals. If the case lacks current medical evidence (within the last 6 months), the claimant should be requested, as part of the standard LWEC modification development process, to provide a narrative medical report within 30 days that addresses the nature and extent of any employment-related residuals of the original injury. The Postal Service should also be requested to provide any medical evidence in its possession that would assist OWCP in determining whether there is a medical basis to modify the LWEC. This will provide information on the claimant's current medical condition, and it is essential where

employees may not have been requested to provide recent medical evidence because they have a zero LWEC rating or have not recently sought medical care for the employment-related condition.

3. In an effort to proactively manage these types of cases, OWCP may also undertake further non-medical development. OWCP may request the Postal Service to address in writing whether the position on which the LWEC rating was based was a bona fide position at the time of the LWEC rating. The Postal Service should be directed to review its files for contemporaneous evidence concerning the position. The Postal Service should be granted 30 days to submit evidence and advised that failure to submit evidence may result in OWCP issuing a decision based on the evidence of file, including the evidence submitted by the claimant. **No payment should be made during this period of development.**
4. If after development and review, the evidence establishes that the LWEC rating was proper and none of the criteria were met to modify the LWEC, then the claimant is not entitled to compensation, and a formal decision denying modification of the LWEC and the claimed compensation should be issued.
5. If the medical evidence establishes that the employment-related residuals of the injury have ceased, a proposed decision to both modify the LWEC and terminate benefits should be issued because (a) the claimant's medical condition has changed and that is one of the reasons to modify an LWEC and, (b) the medical evidence of file now supports no ongoing residuals related to the work injury. The two issues are linked and both must be addressed in a situation like this.
6. If the evidence establishes the LWEC decision was correct, but the medical evidence establishes that the original accepted condition has worsened, then the LWEC rating meets a *Strong* criterion for modification (see Reference on modification), and the CE should issue a decision modifying the LWEC and authorize payment based on the CA-7 (after determining the appropriate pay rate).
7. If the CE evaluates the available evidence and finds that the employee or the employer has presented persuasive evidence that the position was odd lot or sheltered, then the LWEC rating meets another *Strong* criterion for modification (that the original rating was in error). If that is the case, the CE should issue a decision modifying the LWEC determination and authorize payment based on the CA-7 (after determining the appropriate pay rate).
8. If the LWEC is modified, payment can be made for total wage loss and the claimant can be placed on the periodic roll. The case will then fall into the Disability Management universe. Since these cases stem from the NRP process, placement with the previous employer is not a reasonable option, so other disability management efforts must be pursued with actions leading to a vocational rehabilitation referral. While not required, in some cases nurse referrals may be useful to arrange functional capacity evaluations, or to clarify work tolerance limitations or some other medical aspect of the case. In many instances though, CE medical management will likely be the first disability management action. These actions may include development to the treating physician or referrals for second opinion and, if needed, referee examinations. Once work tolerance limitations are received that represent the weight of medical evidence in the case, a referral for vocational rehabilitation should be made. All vocational rehabilitation options should be considered, including work hardening and Assisted Reemployment.

B. LWEC decision HAS NOT been issued –

1. If the claimant has been on light duty due to an injury related condition without an LWEC rating (or the CE has set aside the LWEC rating as discussed above), payment for total wage loss should be made based on the CA-7 as long as the following

criteria are met:

- the current medical evidence in the file (within the last 6 months) establishes that the injury related residuals continue;
- the evidence of file supports that light duty is no longer available; and
- there is no indication that a retroactive LWEC determination should be made. (Note - Retroactive LWEC determinations should not be made in these NRP cases without approval from the District Director.)

2. If the medical evidence is not sufficient, the CE should request current medical evidence from both the Postal Service and the claimant. As with the previous scenario, the claimant should be requested to provide a narrative medical report within 30 days that addresses the nature and extent of any employment-related residuals of the original injury.
3. If payment is made and the claimant is placed on the periodic roll, the case must then be entered into Disability Management with appropriate action as outlined in the above section.

II. Claims for INTERMITTENT PARTIAL DISABILITY

A. LWEC decision HAS been issued -

If a formal LWEC decision has been issued, the CE must develop the evidence to determine whether a modification of that LWEC is appropriate. Since the initial actions are identical to those found in Section I. Claims for TOTAL DISABILITY / LWEC decision HAS been issued, the CE should follow steps 1 though 5 in that section and then proceed with the following for claims for intermittent partial disability:

1. If the evidence establishes the LWEC decision was correct, but the medical evidence establishes that the original accepted condition has worsened, then the LWEC rating meets a *Strong* criterion for modification (see Reference on modification), and the CE should issue a decision modifying the LWEC and authorize payment for the intermittent hours on the CA-7 in conformity with #3 below.
2. If the CE evaluates the available evidence and finds that the employee or the employer has presented persuasive evidence that the position was odd lot or sheltered, then the LWEC rating meets another *Strong* criterion for modification (that the original rating was in error). If that is the case, the CE should issue a decision modifying the LWEC determination and authorize payment for the intermittent hours on the CA-7 in conformity with #3 below.
3. If the LWEC has been modified and it has been determined that payment can be made for intermittent hours based on the CA-7, the CE must be careful to pay only for the hours when light duty was not available. The evidence must establish that a certain number of hours of light duty have been withdrawn, thereby establishing a recurrence of disability for those hours for which light duty is not available.

   Note - The penalty provision of termination for refusal or abandonment of suitable work can **not** be utilized in any case where USPS is making ongoing and/or daily determinations of how many hours of work are available. OWCP will not consider such offers as potential offers of suitable employment within the meaning of FECA, as they do not meet the regulatory and procedural criteria for that provision.
4. Like claims for total disability, a payment in these cases will also result in a Disability Management record (DM code PLP) requiring action. While not required, in some cases nurse referrals may be useful to arrange functional capacity evaluations, or to clarify work tolerance limitations or some other medical aspect of the case. In many

instances though, CE medical management will likely be the first disability management action. These actions may include development to the treating physician or referrals for second opinion and, if needed, referee examinations.

- If after some period of time all light duty is withdrawn, the CE must be sure to close this Disability Management record (CRN) and create a new record based on the total disability status.

B. LWEC Decision HAS NOT been issued –

1. If the claimant has been on light duty due to an injury related condition without an LWEC rating (or the CE has set aside the LWEC rating as discussed above), payment for intermittent wage loss should be made based on the CA-7, as long as the following criteria are met:
    - the current medical evidence in the file (within the last 6 months) establishes that the injury related residuals continue;
    - the evidence of file supports that a certain number of hours of light duty are no longer available; and
    - there is no indication that a retroactive LWEC determination should be made. (Note - Retroactive LWEC determinations should not be made in these NRP cases without approval from the District Director.)
2. If the medical evidence is not sufficient, the CE should request current medical evidence from both the Postal Service and the claimant. As with the previous circumstances, the claimant should be requested to provide a narrative medical report that addresses the nature and extent of any employment-related residuals of the original injury.
3. As outlined above, the CE must be careful to pay only for the hours when light duty was not available. The evidence must establish that a certain number of hours of light duty have been withdrawn, thereby establishing a recurrence of disability for those hours for which light duty is no longer available.

    Note - The penalty provision of termination for refusal or abandonment of suitable work can **not** be utilized in any case where USPS is making ongoing and/or daily determinations of how many hours of work are available. OWCP will not consider such offers as potential offers of suitable employment within the meaning of FECA, as they do not meet the regulatory and procedural criteria for that provision.
4. If payment is made for intermittent hours, the case must then be entered into the Disability Management universe with appropriate action as outlined above in this section.

References:

1. **Wage-Earning Capacity**. Determinations of wage-earning capacity are made in accordance with the criteria of 5 U.S.C. 8115(a), the applicable regulations and the precedent of the Employees' Compensation Appeals Board (ECAB) in this area. In cases such as *Bettye F. Wade*, 37 ECAB 556 (1986), *Leonard L. Rowe*, Docket No. 88-1179 (issued September 27, 1988) and *Alfred A. Moss*, Docket No. 89-846 (issued July 26, 1989), the ECAB pointed out that "wage-earning capacity" is a measure of the employee's ability to earn wages in the open labor market under normal employment conditions given the nature of the employee's injuries and the degree of physical impairment, his usual employment, his age and vocational qualifications, and the availability of suitable employment. Once the claims examiner determines that the selected position is appropriate, the principles set forth in *Albert C. Shadrick*, 5 ECAB 376 (1953), are applied so as to result in the percentage of the claimant's loss of wage-earning capacity.

2. **Actual Earnings LWEC**. In *Lee R. Sires*, 23 ECAB 12 (1971), which is the leading case on this issue, the ECAB expressed the following principles on the proper interpretation of § 8115(a): "Generally, wages actually earned are the best measure of a wage-earning capacity [pursuant to § 8115(a)], *and in the absence of evidence showing they do not fairly and reasonably represent the injured employee's wage-earning capacity*, must be accepted as such measure." [emphasis supplied] The ECAB has found that actual earnings are not the "best measure" of a claimant's wage-earning capacity when there is "evidence showing they do not fairly and reasonably represent" his or her wage-earning capacity. For example, in the case of *Elizabeth E. Campbell*, 37 ECAB 224 (1985), the ECAB held that the claimant's actual earnings as a "cover sorter" did not fairly and reasonably represent her wage-earning capacity because the evidence suggested that the work was both seasonal in nature and constituted make-shift work designed for her particular needs. In *Mary Jo Colvert*, 45 ECAB 575 (1994), the ECAB set aside a determination that the claimant's actual earnings as a part-time clerk fairly and reasonably represented her wage-earning capacity because her hours varied widely and the medical evidence of record established that she was, in fact, totally disabled.

However, in the event that a proper formal LWEC determination is in place, the fact that the employing agency has withdrawn a light duty position does not automatically entitle the claimant to continuing ongoing compensation; in order for compensation to be payable, the evidence must establish a basis for modification of the LWEC. *See FECA Procedure Manual*, Chapter 2-1500-7 (a) (5).

3. **Modification of LWEC**. The ECAB established the following criteria for modifying a formal LWEC decision in *Elmer Strong*, 17 ECAB 226 (1965): (1) The original LWEC rating was in error; (2) The claimant's medical condition has changed; or (3) The claimant has been vocationally rehabilitated. The party seeking modification of the LWEC decision has the burden to prove that one of these criteria has been met. If the claimant is seeking modification on the basis of an increase in wage loss, he or she must establish that the original rating was in error or that the injury-related condition has worsened.

4. **Intermittent Claims for Wage Loss Where an LWEC Rating is in Place**. See *J.J.*, Docket No. 2008-1286, issued March 10, 2009; *Tamara Lum*, Docket No. 2005-0111, issued December 6, 2005. In both of these cases, the Board specifically held that the OWCP is not precluded from adjudicating a limited period of disability following the issuance of a loss of wage-earning capacity decision; indeed, in the *Lum* case, the Board found that the claimant had established disability for work on particular dates. If the CE deems it appropriate under the facts and circumstances of an individual case based on the cases noted above, limited compensation for a particular period may be paid based on CA-7 submissions even where an LWEC rating is in place. For example, intermittent wage loss may be paid where a claimant has a demonstrated need for surgery. **Claimants may <u>not</u> be placed on the periodic roll in such circumstances.**

5. **Recurrence of Disability - Burden of Proof Standard When a Claimant Has Been Working on Light Duty.** To the extent that an employee is claiming a recurrence of disability on the ground that light duty is no longer available, the principles of *Terry R. Hedman*, 38 ECAB 222 (1986) apply. The ECAB stated in *Hedman*: "When an employee, who is disabled from the job he held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he can perform the light-duty position, the employee has the burden of establishing by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that he cannot perform such light duty. As part of his burden, the employee must

show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements." See 20 C.F.R. 10.5(x), which provides a definition of recurrence of disability that includes the situation where the employing agency has withdrawn light duty.

6. **Where An Employee's Light-Duty Job Is Eliminated Due To Downsizing Or A Reduction In Force.** As noted in 20 C.F.R. 10.509, an employee generally will not be considered to have experienced a compensable recurrence of disability as defined in § 10.5(x) merely because his or her employer has eliminated the employee's light-duty position in a reduction-in-force or some other form of downsizing. When this occurs, OWCP will determine the employee's wage-earning capacity based on his or her actual earnings in such light-duty position if this determination is appropriate on the basis that such earnings fairly and reasonably represent the employee's wage-earning capacity and such a determination has not already been made. For the purposes of 10.509, a light-duty position means a classified position to which the injured employee has been formally reassigned that conforms to the established physical limitations of the injured employee and for which **the employer has already prepared a written position description** such that the position constitutes federal employment. In the absence of a "light-duty position" as described in this paragraph, OWCP will assume that the employee was instead engaged in non-competitive employment which does not represent the employee's wage-earning capacity, i.e., work of the type provided to injured employees who cannot otherwise be employed by the Federal Government or in any well-known branch of the general labor market. (In order for 10.509 to be potentially applicable, the USPS must confirm that the position is being eliminated in a "reduction-in-force or some other form of downsizing.")

7. **Application of 5 U.S.C. 8106 (c) (2) Penalty Provision for Refusal, Abandonment or Neglect of Suitable Employment**. Under the FECA, its implementing regulations, procedures and case law, OWCP alone can make a determination that a particular position is suitable within the meaning of 5 U.S.C. 8106. The ECAB has described 5 U.S.C. 8106 (c) (2) as a penalty provision that must be narrowly construed, noting OWCP must consider preexisting and subsequently developed conditions (including non-employment related conditions) in considering whether a position is suitable employment within the meaning of this section. *See Richard P. Cortes*, 56 ECAB 200 (2004). The ECAB has long rejected the contention that employment may be considered suitable based on a general representation by the agency that work is available within medical restrictions. *See Clara M. Jackson*, 33 ECAB 1782 (1982); *Harry B. Topping*, 33 ECAB 341 (1981). Moreover, longstanding FECA procedures do not permit any position of less than 4 hours to be considered suitable for this penalty provision. For these reasons, where claimants are working less than 4 hours a day, OWCP has determined as a threshold matter that it will not consider any application of this penalty provision to this situation. Nor will this provision be applied to circumstances where light duty employment is being sporadically offered for 4 hours or more. This is true even where the USPS contends that it "has provided suitable work," or the claimant contends that the work that is being offered or provided is "not suitable." Suitability determinations implicating the penalty provision in claims affected by the NRP will only be performed in cases that meet all of OWCP's established criteria for such cases; suitability determinations will be performed with strict adherence to all the requirements of the statute, regulations, procedures and case law.

8. Recurrent Pay Rates. Pay rate formulations for compensation are based on the pay rate as determined under section 8101(4) which defines "monthly pay" as: "[T]he monthly pay at the time of injury or the monthly pay at the time disability begins or the monthly pay at the time compensable disability recurs, if the recurrence begins more than six months

after the injured employee resumes regular full-time employment with the United States, whichever is greater....” 5 U.S.C. 8101(4). To be eligible for a recurrent pay rate, there need not be a “continuous” six months of full-time employment prior to the recurrence of disability. *See Johnny Muro*, 19 ECAB 104 (1967); *Carolyn E. Sellers*, 50 ECAB 393 (1999) [citing *Muro* for the proposition that the return to regular full-time employment need not be continuous; a claimant need only work cumulatively for the required six months in regular full-time employment]. However, to be eligible for a recurrent pay rate, the claimant must have returned to “regular” full-time employment. The ECAB has defined “regular” employment, as “established and not fictitious, odd-lot or sheltered,” contrasting it with a job created especially for a claimant. The ECAB has also noted that the duties of “regular” employment are covered by a specific job classification, pointing out that the legislative history of the 1960 amendments to FECA, which added the alternative provisions to section 8101(4), demonstrating that “ Congress was concerned with the cases in which the injured employee had ‘recovered’ or had ‘apparently recovered’ from the injury.” *See Jeffrey T. Hunter*, Docket No. 99-2385 (issued September 5, 2001) [Finding a claimant was not entitled to a recurrent pay rate—he did not return to “regular” employment as he worked only limited duty, as opposed to the full duties of a mail handler after his return to work following his employment injury]. The test is not whether the tasks that appellant performed during his limited duty would have been done by someone else, but instead whether he occupied a regular position that would have been performed by another employee. *See also Eltore D. Chinchillo*, 18 ECAB 647 (1967) [ECAB noted in remanding the case for further development that if the employee only returned to work in a temporary position designed to keep him on the payroll until his future ability to perform shipfitter duties was ascertained, the employee did not resume “regular” full-time employment within the meaning of the statute.]

Disposition: This Bulletin is to be retained in Part 2, Claims, Federal (FECA) Procedure Manual, until further notice or until incorporated into Part 2 of the Procedure Manual.

DOUGLAS C. FITZGERALD
Director for
Federal Employees’ Compensation

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

FECA CIRCULARS

FC 09-01 Current Interest Rates for Prompt Payment Bills and Debt Collect
FC 09-02 Dual Benefits - FERS Cost of Living Adjustments
FC 09-03 Fees for Representatives' Services - Contingency Fees
FC 09-04 Health Benefits Insurance and Life Insurance - General Guidance
FC 09-05 Release of Documents from Federal Employees’ Compensation (FECA) Files

Attachments

FC 09-01 Prompt Payment Interest Rates
FC 09-05 EMPLOYING AGENCY REQUEST FOR COPIES OF DOCUMENTS FROM FECA CASE RECORDS

FECA CIRCULARS--text

FECA CIRCULAR 09 – 01 **February 15, 2009**

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

The interest rate to be assessed for the prompt payment bills is 5.625 percent for the period of January 1, 2009 through June 30, 2009. This new rate has been updated in the Central Bill Payment system tables.

The rate for assessing interest charges on debts due the government has not changed. The interest rate for assessing interest charges on debts due the government remains at 3.0 percent for the period of January 1, 2009 through December 31, 2009.

Ordinarily, the rate of interest charged on debts due the U.S. 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 more than two percent. The rate will be reviewed on July 1, 2009 to determine if the Treasury has changed the rate.

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

DOUGLAS C. FITZGERALD
Director for
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Attachments

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

PROMPT PAYMENT INTEREST RATES

		7/1/99 - 12/31/99	6½%
1/1/09 – 12/31/09	5 %	1/1/99 - 6/30/99	5.0%
7/1/08 – 12/31/08	5	7/1/98 - 12/31/98	6.0%
1/1/08 – 6/30/08	4¾%	1/1/98 - 6/30/98	6¼%
7/1/07 – 12/31/07	5¾%	7/1/97 - 12/31/97	6¾%
1/1/07 – 6/30/07	5¼%	1/1/97 - 6/30/97	6%

7/1/06 – 12/31/06	5¾%	7/1/96 - 12/31/96	7.0%
1/1/06 – 6/30/06	5%	1/1/96 - 6/30/96	5%
7/1/05 – 12/31/05	4½%	7/1/95 - 12/31/95	6%
1/1/05 – 6/30/05	4¼%	1/1/95 - 6/30/95	8%
7/1/04 – 12/31/04	4½%	7/1/94 - 12/31/94	7.0%
1/1/04 – 6/30/04	4.0%	1/1/94 - 6/30/94	5½%
7/1/03 – 12/31/03	3%	7/1/93 - 12/31/93	5%
1/1/03 – 6/30/03	4¼%	1/1/93 - 6/30/93	6½%
7/1/02 – 12/31/02	5¼%	7/1/92 - 12/31/92	7.0%
1/1/02 - 6/30/02	5½%	1/1/92 - 6/30/92	6%
7/1/01 – 12/31/01	5%	7/1/91 - 12/31/91	8½%
1/1/01 - 6/30/01	6%	1/1/91 - 6/30/91	8%
7/1/00 - 12/31/00	7¼%	7/1/90 - 12/31/90	9.0%
1/1/00 - 6/30/00	6¾%	1/1/90 - 6/30/90	8½%

7/1/89 - 12/31/89 9%
1/1/89 - 6/30/89 9¾%
7/1/88 - 12/31/88 9¼%
1/1/88 - 6/30/88 9%
7/1/87 - 12/31/87 8%
1/1/87 - 6/30/87 7%
7/1/86 - 12/31/86 8½%
1/1/86 - 6/30/86 9¾%
7/1/85 - 12/31/85 10%
1/1/85 - 6/30/85 12%

ATTACHMENT TO FECA CIRCULAR NO. 09 – 01

DEBT MANAGEMENT INTEREST RATES

1/1/09 – 12/31/09 3%
7/1/08 – 12/31/08 3%
1/1/08 – 6/30/08 5%
1/1/07 – 12/31/07 4%
7/1/06 – 12/31/06 4%
1/1/06 – 6/30/06 2%
1/1/05 – 12/31/05 1%

1/1/04 – 12/31/04 1%
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 01/01/84 Not Applicable

FECA CIRCULAR NO. 09 - 02 **February 15, 2009**

SUBJECT: Dual Benefits - FERS Cost of Living Adjustments

Effective December 1, 2008, benefits issued by the Social Security Administration (SSA) will be increased by 5.8%. This requires the amount of the Federal Employees' Retirement System (FERS) Dual Benefits deduction to be increased by the same amount, to ensure the dollar-for-dollar offset remains current.

This adjustment will be made from the National Office for all cases that were correctly entered into the iFECS Compensation program. The adjustment will be effective with the periodic roll cycle beginning December 21, 2008. There will be no adjustment or overpayment declared for the period of December 1, 2008 through December 20, 2008.

The historical SSA cost of living adjustments are as follows:

12/01/2008 - 11/30/2009 5.8%
12/01/2007 - 11/30/2008 2.3%
12/01/2006 - 11/30/2007 3.3%
12/01/2005 - 11/30/2006 4.1%
12/01/2004 - 11/30/2005 2.7%
12/01/2003 - 11/30/2004 2.1%
12/01/2002 - 11/30/2003 1.4%
12/01/2001 - 11/30/2002 2.6%
12/01/2000 - 11/30/2001 3.5%
12/01/1999 - 11/30/2000 2.4%
12/01/1998 - 11/30/1999 1.3%
12/01/1997 - 11/30/1998 2.1%
12/01/1996 - 11/30/1997 2.9%
12/01/1995 - 11/30/1996 2.6%
12/01/1994 - 11/30/1995 2.8%

DOUGLAS C. FITZGERALD

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

FECA CIRCULAR NO. 09 - 03 **June 1, 2009**

SUBJECT: Fees for Representatives' Services - Contingency Fees

Questions have continued to arise concerning the representative fee approval process under the Federal Employees' Compensation Act (FECA). Based on 5 U.S.C. § 8127 of the FECA, its implementing regulations and procedures as well as the precedent of the Employees' Compensation Appeals Board (ECAB), the fee application approval process for representatives of FECA claimants is within the discretion of the Department of Labor's Office of Workers' Compensation Programs (OWCP) which has been delegated the responsibility of administering the FECA program. The FECA regulations at 20 CFR Part 10, Subpart H describe procedures for designating a representative as well as the fee approval process before OWCP. See 20 C.F.R. §§ 10.701-703. Pursuant to 20 C.F.R. §10.703, a fee application must be in the form of an itemized statement showing the representative's hourly rate, the number of hours worked, and specifically identifying the work performed and a total amount charged for the representation (excluding administrative costs).

Contingency fee arrangements are not permitted. OWCP considers it unacceptable for a representative to create what amounts to a contingency fee in regard to any FECA matter including schedule awards or to manipulate extremely high hourly rates after the fact in a manner that guarantees a certain percentage fee. As such arrangements essentially amount to contingency fee agreements, they do not comport with OWCP's requirements and thus are not subject to the deemed approved process. While OWCP's current FECA regulations set forth a "deemed approved" method for streamlining the fee approval process and do not specifically prohibit contingency fees, the FECA regulations clearly anticipate use of an hourly rate. In order for the deemed approved process to apply, the claimant must specifically concur with a fee request that comports with the FECA regulatory requirement of an itemized statement and a specified hourly rate.

OWCP's requirement of an itemized statement and an hourly rate in its published regulations at 20 C.F.R. 10.703 makes it apparent that OWCP does not recognize any contract or agreement between representatives and clients for payment of a fee on a contingency basis (any agreement where a client agrees to pay a representative a percentage of any monies paid or recovered as part of an OWCP claim). As noted, OWCP's current regulations anticipate use of an hourly rate. Any question of whether contingency fees were allowable was resolved when ECAB held in Angela M. Sanden, Docket No. 04-1632 (issued September 4, 2004), in a case involving fees for services before OWCP, that contingency fee arrangements are not recognized under FECA, further noting that "the attorney's contingency fee arrangement is illegal under the laws applicable to this case." Section 2-1200-5(b) of the Federal (FECA) Procedure Manual reflects ECAB's holding against the use of contingency fees in the FECA process and describes how a fee may be approved.

ECAB more recently stated in its final rule on changes in the ECAB Rules of Procedure (in rejecting a commenter's urging contingency fees be allowed in fee applications on ECAB appeals in response to ECAB's Notice of Proposed Rulemaking in the Federal Register) that "The Board has found that the use of contingency fees by attorneys handling FECA claims before OWCP is not in keeping with section 8127." ECAB cited Sanden in support of that proposition in their final rule which appears at: http://www.dol.gov/ecab/welcome.html. See F.R. Vol. 73 at 62192 (October 20, 2008). ECAB further noted in its final rule that a representative's failure to follow the statutory approval process may subject that individual to criminal sanctions. See 18 U.S.C. § 292. As ECAB's fee approval process is also based on section 8127 of FECA and the representative fee approvals for work before OWCP may be appealed to ECAB, OWCP follows ECAB's clear guidance in this matter.

Representatives utilizing retainer agreements that amount to contingency fee agreements should be advised to revise their fee agreement in accordance with these instructions. Such cases should be handled as follows:

1. Any fee application submitted by a representative in the form of a contingency fee must be returned to the representative with instructions to calculate the money owed for services rendered on an hourly basis and resubmit the fee application in the proper format as described in 20 C.F.R. §10.703.
2. When the representative resubmits the fee request, the attorney must submit a contemporaneously dated statement from the claimant that acknowledges concurrence with the fee and lists the hourly rate being charged in order for the deemed approved process to apply.
3. Any request by a claimant or representative for OWCP to issue a formal decision in order to allow an appeal should be promptly granted.

If a claims examiner receives an inquiry from a state bar association concerning OWCP's procedures on representative fee approvals (this occurs with increasing frequency), the claims examiner may provide links to the applicable statutory language, regulations and procedures but should refer further questions to the District Director who may consult with OWCP's Division of Federal Employees' Compensation (DFEC) National Office as needed in responding to such requests.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 09 - 04 **June 1, 2009**

SUBJECT: Health Benefits Insurance and Life Insurance - General Guidance

Health Benefits

When a Federal employee enters a leave without pay (LWOP) status, the employing agency is no longer able to deduct for health and life insurance premiums. If compensation for wage loss benefits is payable under the Federal Employees' Compensation Act (FECA), the responsibility for making those deductions transfers to the Office of Workers' Compensation Programs (OWCP).

Health Benefit Insurance (HBI) Enrollment Requirements

Claims with health benefit deductions should not be on the daily roll for more than 90 consecutive days. Generally, claimants who are disabled for more than 90 days should be placed on the Periodic Roll and their health benefits enrollment should be transferred-in to the servicing district office in a timely manner. The sole exception would be when the evidence in the case record clearly indicates a return to work (RTW) in the near future. **Please note that timely transfer-in of health benefits (HBs) is critical, as the information entered in the Integrated Federal Employees' Compensation System (iFECS) is used to report to the Office of Personnel Management's (OPM) Centralized Enrollment Clearinghouse (CLER) system.** OPM/CLER reconciles the health benefits enrollment between iFECS and the HB carriers, matching up deductions with enrollment codes. The Division of Federal Employees' Compensation (DFEC) sends information to OPM on those periodic roll/death roll (PR/DE) cases that have been transferred-in. Cases without a transfer-in will not be reported even though DFEC is making deductions for the HB premiums.

Continued discrepancies due to the lack of a transfer-in will result in the claimant's HBI being terminated by the carrier. This problem can be compounded if/when the claimant's employment is terminated by the employing agency, as it will appear to OPM/CLER that the claimant has no entitlement to health benefits and this will be transmitted to the health benefit provider. Claimants who contact the district office with concerns that their right to health benefit coverage has been terminated must receive a prompt and substantive response given that any inability to confirm health benefit eligibility may have an adverse impact on their and/or their families' ability to receive medical services. If the district office is unable to resolve any issues of entitlement promptly, the district office Fiscal Operations Officer (FOS) should contact the Chief of the Branch of Fiscal Operations, National Office for assistance.

As soon as a claimant has been placed on the periodic roll, claims staff must notify the responsible fiscal personnel in the district office. The claims staff may use the CA-73 or the iFECS referral system to notify the appropriate fiscal personnel and advise them to initiate the transfer-in action. Once the transfer-in process is complete, the HB transfer flag in iFECS should be changed to "Y" and certified. The effective date for this action is the date that the deductions began.

Circumstances other than on-going disability may also trigger the need for a transfer-in of the HB enrollment, including the following:

- If the claimant elects OWCP benefits in lieu of OPM benefits, the servicing district office should request copies of the enrollment documents (SF-2809 forms) from OPM in order to accomplish the transfer-in.

- If FECA death benefits are approved for survivors and the enrollment has already been transferred to OPM, the district office should request copies of the enrollment documents from OPM to complete the transfer-in.

- If the claimant moves and the case record is transferred to a different district office, the new district office should complete the transfer-in process since the claimant is now the responsibility of the new "payroll" office, as that term is used by OPM.

Changes to the health benefits enrollment (the HB Plan) are only made during the annual Open Season period. The exception to this rule is generally due to a "life event" such as birth, marriage, divorce, etc. See the instructions to the SF-2809 for a full listing of all exceptions. (See PM 5-0400.8)

If the claimant is in receipt of compensation for a loss of wage-earning capacity (LWEC) and the periodic payment does not cover the amount of the HB premium, the claimant should be notified and offered a plan that will cost less. If the claimant wants to continue with his/her current plan, the claimant will be required to submit the difference between the LWEC and the HB premium on a quarterly or yearly basis to maintain coverage.

Making HBI Deductions

To authorize and set up these deductions in a compensation payment, the following steps need to be taken:

Determine the code for HBI and/or Life Insurance (LI) from Section 10 on the CA-7 claim form. If the Optional Life Insurance (OLI) code is not provided, but the agency provides information detailing the level of coverage, there is an OLI chart available to determine the correct code to enter. The chart is located on the Department of Labor's website at (http://esa/owcp/dfec/jac/oli.htm). It may also be found at the OPM website, which is http://www.opm.gov/insure/life/reference/handbook/sf50tbl.asp

Determine the date on which DFEC deductions become effective. Generally, the employing agency will make deductions through the last date for which the claimant received pay. Although OWCP deductions for HBI and LI become effective on the first day of LWOP status, DFEC does not actually begin making the HBI and LI deductions until the claimant has been in receipt of compensation for 28 days. Once the claimant has received compensation for more than 28 days, deductions should be made retroactively to the date compensation started. From that point on deductions should begin on the day immediately following the ending date of the last deduction.

The iFECS Compensation system has the ability to deduct partial premiums on a daily basis or for periods of compensation less than a full pay period, but the effective date of the deductions is dependent upon the employing agency. The deductions by the employing agency may occasionally run through the end of the pay period (rather than the first day of LWOP) in which the claimant last worked. If that is the case, DFEC deductions for HBI and LI become effective the next calendar day. If this date is not apparent from the CA-7 or from other documentation in file, the employing agency should be contacted to determine the date of last deduction. Once verified, the appropriate date should be documented in the case record.

Termination of HBI Enrollment

A claimant's health benefit enrollment can be terminated if:

- the claimant returns to work in the private sector, with no LWEC. (If there is some LWEC and OWCP is continuing to pay partial benefits, the deductions can be maintained if the claimant chooses to do so unless there is a return to work with the USPS. In those cases the USPS will always make the HBI/LI deductions.)

- the claimant is no longer eligible for compensation benefits.

- the claimant/beneficiary dies. (If the claimant dies and we are accepting the widow/er's claim for death benefits, request that the name of the enrollee be CHANGED to that of the widow/er, and ensure the coverage level is appropriate.)

If a claimant requests termination of his/her health insurance it is usually irrevocable and they may not re-enroll in the Federal Employees Health Benefits (FEHB) Program. Consult the SF-2809 instructions for all of the allowable reasons for reinstatement. Note that suspension of HBI (rather than termination) is possible if the claimant is enrolling in a Medicare/Medicaid based plan such as TRICARE or CHAMPVA. In these instances a letter is sent to the claimant advising them of the actions needed to suspend or reinstate coverage.

Life Insurance

Since DFEC does not enroll claimants in life insurance or make any changes to existing enrollments, any inquiries about enrollment should be referred to the claimant's employing agency, OPM, or the Office of Federal Employees Group Life Insurance (OFEGLI).

Basic Life Insurance (BLI)

Federal employees are automatically enrolled in BLI on the date employment begins unless they waive the coverage. However it cannot be assumed that every employee has BLI coverage. Deductions should only be made for BLI if DFEC receives verification that the claimant does in fact have the coverage. Note that premiums for BLI are free for all claimants with a date of injury prior to January 1, 1990. Deductions should be made for any claim with a date of injury after this date. Lastly, BLI premium deductions automatically stop at age 65. The BLI coverage then begins to reduce at a rate of 2% per month, until it reaches 25% of its value. Though the claimant is not paying premiums, they will always maintain that 25% coverage. Should the claimant die after the BLI coverage is reduced, the beneficiary/survivor will be entitled to whatever reduction level the BLI has reached at the time of death.

Optional Life Insurance (OLI)

In order to be eligible for OLI, the claimant must also be enrolled in BLI, unless the date of injury is prior to January 1, 1990. In that case the BLI coverage is free, so there is no need to key the deduction. The premiums for OLI are withheld until the claimant reaches age 65, and then they will automatically stop at the first full periodic roll payment after the claimant's 65th birthday. However, the claimant can elect to continue their Option B and/or Option C coverage past age 65. This is a "Post 65 Election" and it is open to all claimants who currently have Option B and/or C life insurance coverage. Note that this is not an opportunity to enroll in life insurance and elect coverage. A notice is sent to the claimant by DFEC two months prior to their 65th birthday warning them that their coverage will stop unless they contact OPM and elect to continue it. Should they elect to continue coverage past age 65, OPM will notify DFEC of the election and the level of coverage that is being

maintained. Currently it is only possible to elect to continue Options B and C; Option A will always stop at age 65.

Post Retirement Basic Life Insurance (PRBLI)

At age 65, BLI coverage reduces by 75% in increments of 2% per month. Federal employees who retired or separated from Federal employment and continue to receive benefits from either DFEC or OPM on or after December 9, 1980, have the option of paying an extra premium for No Reduction or 50% Reduction in BLI, which is PRBLI. If the claimant selects a 50% reduction, coverage will reduce in 2% increments per month to the coverage option chosen. Claimants must elect this coverage when separated or retired from federal employment (usually after twelve months in LWOP status). DFEC is notified of this election via Form RI 76-13 from OPM and coverage is effective immediately. The deductions and coverage will continue until death or the claimant elects to reduce coverage. Note that prior to age 65, the claimant must pay for BOTH BLI and PRBLI if they elect it. At age 65 the BLI deduction will stop, though the PRBLI deductions will continue.

Upon notification of a PRBLI election, the claims examiner should adjust the periodic roll payment to include PRBLI and have the adjustment certified. The "75% reduction" option is free, and the "50% Reduction" and "No Reduction" options are calculated by iFECS. You must use the annual salary provided by OPM on the RI 76-13 form for PRBLI. This is considered the "final" annual salary for life insurance purposes. That figure should always be used when keying LI deductions, even if it is different from the annual salary used to calculate compensation.

Dental and Vision Insurance (FEDVIP)

Unlike health benefits and life insurance deductions, there is currently no process for Dental and Vision deductions to be added into the existing periodic roll payment by the claims examiner. This action must be taken by the National Office, and it is done when notified of coverage via a monthly update from OPM. Once notified, the National Office will add the deductions to the claimant's periodic roll payment and no action is required by the district office.

As with life insurance, DFEC does not enroll claimants in Dental/Vision benefits or make any changes to existing enrollments. Should the claims examiner receive a question from a claimant concerning this coverage, they should be advised to contact the FEDVIP program directly at (877) 888-3337. The claimant should indicate that they receive workers' compensation benefits so that their coverage can be added to the monthly update process noted above.

If the periodic roll payment is deleted and later re-entered for some reason, the Dental/Vision deduction will not be saved during the re-entry of the plate. Since it cannot be entered locally, the Chief of the Branch of Fiscal Operations, National Office must be contacted for assistance. Seek local guidance on your point of contact to initiate this communication with the National Office.

DOUGLAS C. FITZGERALD
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. 09 – 05 **August 26, 2009**

SUBJECT: Release of Documents from Federal Employees' Compensation (FECA) Files

This circular is intended to provide guidance in situations where information or copies of information are requested from a claimant's FECA case file. While such requests may come from the claimant or his/her authorized representative, the Department of Labor or employing agency Office of Inspector General, claimant's former spouse or other entity, this circular focuses primarily on what information may be requested by the employing agency and when it may be provided. Because FECA case files are governed by the Privacy Act of 1974 and because FECA case file documents contain Personally Identifiable Information (PII), great care must be taken in handling requests for information. The extent to which information may be released out of a FECA case file is governed by the Privacy Act. Descriptions of the agency's role in the claims process are set forth in the FECA statute, its implementing regulations, and guidance such as the program Procedure Manuals and the Agency Handbook, CA-810. While the agency is not a party to the claim, the agency plays a critical role in the FECA process, particularly in return to work; it may request and receive documentation, including medical reports, to fulfill its role in the claims process.

Background:

All records relating to claims for FECA benefits are covered by the government-wide Privacy Act system of records entitled DOL/GOVT-1. Information from the FECA file may only be released pursuant to a need to know within DOL, a published routine use, a signed Privacy Act waiver, or a court order from a court of competent jurisdiction. Release of information in accordance with a routine use must be consistent with the purpose for which the file was created, which is the administration of the FECA case.

The FECA regulations at 20 C.F.R. § 10.11 make clear that the protection, release, inspection and copying of records covered by DOL/GOVT-1 should be carried out in accordance with the rules, guidelines and provisions of Subpart A of the FECA regulations, as well as those contained in 29 C.F.R. parts 70 and 71, which are the Department's regulations implementing the Freedom of Information Act (5 U.S.C. 552) and the Privacy Act (5 U.S.C. 552a) respectively, as well as with the notice of system of records and routine uses published in the Federal Register. The Office of Workers' Compensation Programs (OWCP) has determined that records covered by DOL/GOVT-1 may not be used in connection with a personnel action absent consent of the subject of the record. It is not permissible to use or release FECA documents in connection with personnel matters unless they have first obtained the claimant's written consent. Any questions an agency has concerning the disclosure of FECA-related documents or uses of such documents by the agency should be referred to the OWCP for resolution. 63 Federal Register 56752, 56753 (October 22, 1998).

A "routine use" authorizes disclosing information from the FECA claim file without first obtaining the claimant's permission—such disclosure is acceptable because the routine use is listed and published in the Privacy Act Systems Notice for DOL/GOVT-1, and because OWCP has concluded that the anticipated use of the document is consistent with the purpose for which the information was collected. These routine uses include: sending the record to medical providers asked by OWCP to examine or treat the claimant; providing relevant information about the nature and mechanism of the injury or illness to health and safety officials within the employing agency[1]; providing relevant documents to nurses and rehabilitation counselors assigned by OWCP to work on the case; providing documents to employing agency personnel (but only for purposes related to the claim, and not for other reasons such as personnel actions); providing documents pertaining to the factual circumstances of the case to credit bureaus; and others. A listing of the universal routine uses which apply to all Department of Labor (DOL) system of records can be found at http://www.dol.gov/sol/privacy/intro.htm. A listing of the routine uses specific to DOL/GOVT-1 can be found at http://www.dol.gov/sol/privacy/dol-govt-1.htm. [See DOL Privacy Act System of Record Notices, 67 FR 16825, at 16827-16828 (April 8, 2002).] Routine use b for DOL/GOVT-1 authorizes release of case file information "To federal agencies that employed the claimant at the time of the occurrence or recurrence of the injury or occupational illness in order to verify billing, to assist in administering the FECA, to answer questions about the status of the claim, to consider rehire, retention or other actions the agency may be required to take with regard to the claim or to permit the agency to evaluate its safety and health program."

Handling requests:

1. Regarding general requests from employing agencies, OWCP's Division of Federal Employees' Compensation (DFEC) may grant requests from agencies for records pertaining to their employees. If records are to be released, Claims Examiners (CEs) should ensure that the requestor is agency-authorized, and should require proper identification before releasing only that information directly relevant to the request. For example, if an agency needs to formulate a job offer and needs to know a claimant's medical restrictions, relevant medical reports may be released. Blanket release of the entire case record is not appropriate, except to an investigative body (DOL Office of Inspector General (OIG) or Employing Agency OIG), or to an Agency Injury Compensation Specialist who must understand that indiscriminate or widespread further release of the FECA record within the employing agency is not authorized or permitted by OWCP/DFEC.[2]

2. Employing agency personnel who inquire about releasing claims-related material from their files should be referred to 20 C.F.R. 10.10-10.13, as well as paragraph 9-2 of Injury Compensation for Federal Employees (Publication CA-810).

3. An agency representative may ask to inspect files at the district office. OWCP will accommodate all such requests subject to logistical and physical limitations, including reasonable advance notice of the visit and a list of cases to be reviewed. Once the agency representative has presented satisfactory identification, requested documents from the FECA claim file may be released. However, the agency representative must provide a separate statement regarding the reason for any requested documents for each FECA claim for which copies of documents are requested. Release of complete case records to employing agencies will occur very infrequently and the employing agency must establish a reasonable need for such a request.

4. Release of documents within the FECA case record to employing agencies is a permitted

routine use. However, the Office may decline to release information not pertinent to the investigation or audit or may request the agency to provide additional rationale for requesting the information.

5. While documents within the FECA case record may be released to employing agencies, the use of these copies **must** be consistent with the reason the information was collected. In practice, this means that the use must be connected in some way with the compensation claim. Absent truly unusual circumstances (such as a FECA claimant's improper actions in the FECA claim forming the basis of a disciplinary action and with explicit DOL permission), agencies may not use copies of information from claim files in connection with EEO complaints, disciplinary actions or other administrative actions without the employee's consent.

6. A request for copies of documents contained in the FECA case record received from an employing agency must contain a reason for the request. If the reason stated is consistent with the purpose for which the information was collected, such copy requests will generally be honored. The CE is not required to determine whether the evidence of record indicates the claimant is currently capable of returning to work before providing the employing agency injury compensation specialist (or an individual performing those duties) with current medical reports for the stated purpose of attempting re-employment of the injured worker.

7. Whether in writing or in person, the agency representative may make a copy request using a standard request form attached to this Circular, or may use any signed statement which includes the required information. All such copy requests will be included in the FECA case record.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

Attachement 09-05

EMPLOYING AGENCY REQUEST FOR COPIES OF DOCUMENTS FROM FECA CASE RECORDS (place in case file)

Claim Number: _____

Claimant Name: _____

As an authorized representative of _____ I am requesting a copy of the following documents from the above noted FECA claim record:

_____

_____

_____

These copies are being requested for the following reason(s):

_____

_____

_____

I understand that the use of these document copies must be consistent with the reason for which they were collected and may not be used in connection with personnel actions without the employee's consent.

Signature: _____

Date: _____

TRANSMITTALS

FT 09-01 modifies Part 0, Chapter 0100
FT 09-02 modifies Part 1, Chapter 0200
FT 09-03 modifies Part 6, Chapter 0300
FT 09-04 modifies Part 6, Chapter 0200
FT 09-05 modifies Part 2, Chapter 1000
FT 09-06 modifies Part 2, Chapter 0401
FT 09-07 modifies Part 2, Chapter 0809

FECA TRANSMITTALS (FT)--TEXT

FECA TRANSMITTAL NO. 09-01
December 1, 2008

RELEASE - REVISION TO CHAPTER 0-0100, INTRODUCTION TO FECA AND DFEC, PART 0 - OVERVIEW, FEDERAL (FECA) PROCEDURE MANUAL
EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 1, Jurisdiction of District Offices has been updated to reflect all changes in jurisdiction including moving most of the Special Jurisdiction claims to the Cleveland district office, moving a part of the Maryland claims to the Philadelphia district office and, most recently, moving Arkansas claims to the Kansas City district office.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
0	0-0100	i	0	0-0100	i
0	0-0100	ex. 1	0	0-0100	ex.1

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

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

FECA TRANSMITTAL NO. 09-02
December 1, 2008

RELEASE - REVISION TO CHAPTER 1-0200, GENERAL JURISDICTION, PART 1 - MAIL AND FILES, FEDERAL (FECA) PROCEDURE MANUAL

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 1-0200 has been revised to reflect the change in jurisdiction for cases originating in Arkansas. The responsibility for these cases moved from the Dallas district office to the Kansas City district office effective October 1, 2008.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

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

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

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

RELEASE - REVISION TO CHAPTER 6-0300, DEBT LIQUIDATION, PART 6- DEBT MANAGEMENT, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 09-03 **June 1, 2009**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 6-0300.19 has been revised to establish procedures for collection of moneys paid for periods after the death of a claimant. Exhibit 1 has been updated to reflect the current debt interest charges.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
6	6-0300	i	6	6-0300	i
6	6-0300	25-27	6	6-0300	25-29
6	6-0300	Exhibit 1	6	6-0300	Exhibit 1

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

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

RELEASE - REVISION TO CHAPTER 6-0200, INITIAL OVERPAYMENT ACTIONS, PART 6- DEBT MANAGEMENT, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 09-04 **June 15, 2009**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 6-0200.4(e)(2) has been expanded to establish procedures for recovery of existing debts from the estate of a deceased claimant.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
6	6-0200	i	6	6-0200	i
6	6-0200	13-24	6	6-0200	13-24

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

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

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

FECA TRANSMITTAL NO. 09-05 **June 1, 2009**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-1000.17.d. regarding offset of compensation based on voluntary separation incentive payments (VSIP). Previous offset instructions differentiated between VSIPs paid based on a specific number of weeks of salary and those capped at a specified amount of money. However, in order to be equitable to all claimants, offsets for both types of payments should be computed in the same manner regardless of the way the employing agency has offered separation pay. This section has been expanded to include instructions on calculating the number of weeks of salary a specified capped separation pay represents.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1000	i	2	2-1000	i
2	2-1000	29-32	2	2-1000	29-32

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

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

RELEASE - REVISION TO CHAPTER 2-0401, AUTOMATED SYSTEM SUPPORT FOR CASE ACTIONS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 09-06 **September 28, 2009**

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-0401 has been revised in its entirety with respect to the current automated case management system. Three paragraphs (Call-Ups, TPCUP Codes and Reports) were deleted since the information was no longer applicable.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove			Insert		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
2	2-0401	1-13	2	2-0401	1-10

Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

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

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

RELEASE - REVISION TO CHAPTER 2-0809, STATEMENTS OF ACCEPTED FACTS, PART 2 – CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 09-07 **September**

28, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-0809 has been revised in its entirety. The chapter has been streamlined and updated to include new language, a change in the structure of the Chapter, and the inclusion of exhibits containing sample Statements of Accepted Facts (SOAFs).

With the exception of paragraphs 1 and 2, the remaining paragraphs have been reordered and consolidated. There are now eight paragraphs instead of fourteen.

Paragraph 3 “Definitions” has been deleted.

Paragraphs 4 “Nature of SOAF,” and 6 “Need for SOAF,” have been incorporated into paragraph 2, “Introduction.”

Paragraphs 7 “Length of SOAF,” 8 “Form of SOAF,” and 11 “Requirements for SOAFs” have been combined into paragraph 4 and renamed “Composition of the SOAF.”

Relevant portions of paragraph 10 “Weighing Factual Evidence and Drawing Conclusions” have been incorporated into “Responsibilities of the CE” and “Composition of the SOAF,” Paragraphs 3 and 4, respectively.

Paragraph 13 has been changed from “Additional Elements” to “Optional Elements,” and is now paragraph 6.

Paragraph 8 “Modification of SOAFs” has been added to specifically address the necessity of modifying or correcting a prior SOAF when that SOAF no longer accurately reflects the relevant current facts of a case.

Four sample Statement of Accepted Facts have been added as exhibits.

DOUGLAS C. FITZGERALD
Director for
Federal Employees' Compensation

Remove			Insert		
Part	Chapter	Paragraphs	Part	Chapter	Paragraphs
2	2-0809	1-14	2	2-0809	1-8 Exhibits 1-4

Because transmittal of the FECA Procedure Manual is primarily electronic, DFEC is discontinuing the practice of inserting page numbers when an entire chapter is reissued.

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

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

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