BCT-FY98

This infobase contains a numerical index of all FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 1998, as well as the text of these issuances.

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

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FECA BULLETIN NO. 98-01

Issue Date: November 30, 1997

Expiration Date: November 29, 1998

Subject: Case File and Bill Batch Imaging

Background: While cases are before the Employees' Compensation Appeals Board (ECAB), issues often arise which are not related to the issue(s) for which the cases are before the Board. In the past, when a case file was requested by the Board, it was transferred to the National Office (T51), where the case record itself was sent on to the Board, and the case jacket, CA-800, and incoming correspondence were retained in the Branch of Hearings and Review. Claims examiners in the Branch of Hearings and Review were responsible for taking case actions on issues which were not before the Board, without the benefit of the case record or prior experience with the case.

Medical bill batches are generally retained in the district offices for a minimum of two years, after which they can be retired. Finding space for storage of bill batches has been difficult, as has retrieving particular bill batches when needed for review.

During the past several months, the Division of Federal Employees' Compensation (DFEC) has developed a pilot using imaging technology to assist in the processing of cases before the ECAB, and to enhance bill batch maintenance. Each district office has been provided with scanners, personal computers with monitors large enough to view imaged documents, imaging software, and training on how to use this new technology. A centralized imaging center has been established in the National Office. Cases going to the ECAB and medical bill batches have been imaged. An imaged case tracking system has been established to keep track of the physical case file associated with an imaged case.

Reference: FECA Procedure Manual, Chapter 2-1603.4-5, Chapter 5-0200.7.

Purpose: To describe new guidelines and procedures for case file and bill batch imaging.

Applicability: All staff in the district offices, National Office, and the FEC Imaging Center.

Action:

1. Effective November 24, 1997, when a district office receives a request for a case file from ECAB, the electronic records for the case file will not be transferred to the ECAB (T51). Instead, the district office will remain responsible for the case, and the following actions will be taken:

a. National Office adds the case to the imaged case tracking program;

a. the district office:
   (1) runs the CASE642 report, "Image Tracking Inquiry" showing the ECAB request; this report should be run on a daily basis (see item 2 below);
   (2) locates the case file;
   (3) files down any documents that are loose in the file, in the appropriate order; if actions are pending a note is made on the Sequent and a call-up established by appropriate staff;
   (4) completes a form CA-67 (case transmittal sheet) to list the case(s) being sent;
   (5) mails (certified or overnight) the case(s) with the jackets and CA-67 to the FEC Imaging Center (FIC);
   (6) enters the date that each case was mailed in the imaged case tracking program (option 38 on the FECS001 Case Management menu is "Imaged Case Update").

The case file location changes to NB1 automatically when the mailing date is entered.

b. FIC:
   (1) receives the case file;
   (2) images and indexes it (see items 9 and 10 below for a description of indexing);
   (3) updates the imaged case tracking program with the date received, date imaged, and date mailed to National Office;
   (4) delivers the case file to the National Office mail room.

Once the imaging date has been entered on the imaged case tracking program, the case location in the District Office changes to NB2 overnight.

c. The National Office:
   (1) receives the case file;
   (2) copies the CA-800s;
   (3) marks the file "Imaged";

(4) updates the imaged case tracking with the date received, the issue code (see item 14 below), and comments (if any);
(5) delivers the case file and copy of the CA-800 to ECAB;
(6) mails the case jacket and the original CA-800 back to the district office (see paragraph 3 below).

d. When the ECAB is finished with the case file, the National Office mail room will:
(1) scan the ECAB decision and any accompanying documents; mark documents "document imaged";
(2) send the case contents and the ECAB decision back to the district office;
(3) update the imaged case tracking with the date mailed to the district office.

e. The district office:
(1) receives the case contents;
(2) places the contents back into the permanent jacket;
(3) updates imaged case tracking with the date the case was received;
(4) reviews the ECAB decision and accompanying documents and takes appropriate action.

The case location changes to NB3 automatically as soon as the received date is entered by the district office.

2. The CASE642 report, which is "Image Tracking" under the FECS002 (FECA Report Generation) Menu, lists cases which have been requested by ECAB, but for which the district office has not yet entered the date the case was mailed to the FIC. The report can be simply viewed on the screen or printed. The report should be run daily to track outstanding ECAB requests for cases. It should be noted that the existing daily report which requests cases for both ECAB and Hearings and Review will continue to include ECAB cases for at least a period of time.

3. As previously indicated, after a case file has been imaged and is delivered to the National Office mail room, the case jacket and CA-800 will be returned to the district office. The case jackets and CA-800s should be retained in the district office, either in a separate location in the file room, or another special location. Any mail received in the district office after the case has been mailed to the FIC needs to be scanned, including mail received after the case contents with ECAB decisions have been returned to the district office. If multiple copies of a document are received, such as an original of a medical report plus two copies, only one copy should be scanned and dropfiled. Prior to scanning, the district offices should ensure that the case is showing a location of NB2 or NB3 and that an accurate case file number is present on each page to be scanned. If the case location is NB1, the mail should be held until the location changes to NB2, then it can be scanned. If there are several pages of mail for the same case file, and each page does not have the case file number on it, a header sheet indicating that the following xx

pages are all for case file xx-xxxxxxx may be used. Scanned mail should be stamped as "document imaged," and maintained in a batch in the file room until verification that the mail has been indexed by the FIC. The mail should then be dropfiled in the appropriate case jacket.

4. On a daily basis, the FIC will send to each office, via e-mail, a list of case files for which new mail has been indexed and appended to the case file. Each office has identified the recipients of this e-mail for their office. Receivers of the e-mail are responsible for ensuring that the responsible claims examiners are notified that there is new mail in their cases.

5. Any mail which must receive special tracking (CA-7, CA-
8, CA-2a, CA-16) should be entered into the appropriate tracking system, and then given to the scanner.

6. Once a case file has been imaged, all subsequent case actions should be taken based upon the imaged case. Obviously, while the case contents are with the ECAB, the imaged case must be the basis for case actions taken. Once the case file contents have been returned from the ECAB, the imaged file becomes the official file. Except for unusual circumstances, the case file contents should not move from the file room (special location) again.

7. No imaged files and case records should be transferred between district offices while the case is before the ECAB (case location NB1 or NB2). After the case contents have been returned from the ECAB (case location NB3), the case may be transferred in accordance with existing procedures.

8. Any correspondence or internal documents produced in an imaged case that would normally be filed in the case file must be scanned and then dropfiled, in accordance with item 3 above. This includes letters (including decisions in any format) to claimants and others, payment worksheets, reports, statements of accepted facts, CA-110s, etc.

9. Each document in an imaged case file is indexed by the FIC. Indexing allows the user to identify documents needed for review more readily. Indexing categories for complete case files imaged are:

a. Medical evidence - includes medical reports, office notes, hospital records, and letters to medical providers;
b. Forms - includes only certain forms: CA-1, CA-2, CA-2a, CA-4, CA-5, CA-6, CA-7, CA-7a, CA-7b, CA-8, CA-12 (most recent two only), CA-16, CA-20, CA-800, CA-1032 (most recent two only), and OWCP-5 (also a, b, and c);
c. Decisions (most recent two, or within the past year, which ever is greatest); and
d. Miscellaneous - includes everything else.

10. For case files imaged prior to September 1997, and for new mail (in all previously imaged cases), a more extensive indexing has been/will be done, which, in addition to the categories

shown in item 9, includes:

a. Payment documentation - includes payment work sheets, ACPS reports, and CA-7s and CA-8s;
b. Congressional - includes inquiries from Congressional offices and responses;
c. Communication - includes general correspondence, both incoming and outgoing, CA-110s, transmittal documents, and memoranda to the file;
d. All other forms.

11. A date is associated with all indexed documents, other than those indexed prior to November 24, 1997 and classified as miscellaneous. For the forms, the date is the date the form was signed. For medical evidence, the date is the date of the report or letter. For decisions, congressionals, and communications, the date is the date of the decision, etc. Documents are imaged in the order they are filed in the case file, and should therefore be in approximate date of receipt order.

12. If a piece of mail or an internal document has been scanned, but not yet indexed by FIC, it will not be viewable by making an inquiry using the case file number. Mail will be viewable within 18 hours if it is scanned by 12:00 noon, district office time. If the mail is scanned after noon, indexing will take an additional day.

13. When updates are made to the CA-800 in an imaged case, the paper CA-800 will be updated, and the updated CA-800 should be rescanned so that the current version may be viewed.

14. Even though many cases before the ECAB will be available through imaging in the district offices, and district offices will be responsible for maintaining the imaged case while it is before the ECAB, district offices may not take action on any issue which is simultaneously before the Board. Decisions may be issued by the district offices on issues which are not before the Board. Issue codes and comments are entered by the National Office into the imaged case tracking program, and may be viewed in the district offices under item 31 of the FECS001 query menu. For example, if a case file is with the Board for an appeal on a schedule award, the district office may take action on a claimed recurrence of disability for work. The issue codes are as follows:

01—Time
02—Civil Employee
03—Fact of Injury
04—Performance of Duty
05—Causal Relationship
06—Continuing Injury-Related Disability
07—Recurrence
08—Schedule Award
09—Overpayment
10—COP

11—LWEC
12—Pay Rate
13—Attorney Fee
14—Refusal/Obstruction of Examination
15—Denial of medical treatment
16—Failure to accept suitable job
17—Forfeiture
18—Non-cooperation with Rehabilitation efforts
19—Reconsideration Decision (not merit review)
20—Denial of hearing
21—Compensation Rate
22—Third Party
23—Other

15. The imaged record should be used to produce copies of documents from the case file, such as when a copy of the file is requested under the Privacy Act, or a copy of all medical evidence is needed for a second opinion evaluation. If the number of documents to be printed is large, printing should be done in smaller blocks of no more than 35 pages at a time. If a large number of pages are involved, the FIC should be notified. The FIC will generate a copy of the case file and mail it to the district office, so that it will be received within two days of the request. The customary charges for second copies still apply.

16. In addition to imaging case files going to ECAB, all district offices have the ability to image medical bill batches. The bill batches will be imaged after they are keyed by data entry personnel. Bill resolvers may work from either the actual bill batches, or the bill images. Detailed procedures for bill batch imaging will be issued under separate cover.

17. The appearance and functioning of the imaged document screens have been addressed in the training which has been conducted in each district office. A user guide is under development and should be available within the next month. In the meanwhile, the training materials can be used as a user guide.
18. Doubled cases will be imaged as a single case file, using the master file number. The subsidiary files are not cross-referenced in the imaged file data base. Therefore, if one wishes to view a subsidiary record of an imaged file, the master file number should be used. The presence of the CA-800 and/or CA-1 or CA-2 within the imaged record should help to delineate separate injury records.

19. Once a case has been imaged, all secondary appeals (such as a request for a hearing on a new decision, or another appeal on the case) will be conducted based upon the imaged record.

20. Cases which were transferred to T51 prior to the beginning of the imaging pilot will not be imaged. Maintenance of these files will continue to be performed by the Branch of Hearings and

Review.

Training for all personnel affected by these changes should be conducted no later than November 21, 1997.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 98-02

Issue Date: January 2, 1998

Expiration Date: January 1, 1999

SUBJECT: ADP - Automated Compensation Payment System (ACPS) and Debt Management System (DMS) Report Schedule - 1998

PURPOSE: To provide the 1998 schedule for processing the periodic disability and death payrolls under the ACPS and the DMS weekly and monthly reports for calendar year 1998.

APPLICABILITY: All appropriate personnel are to be made aware of the periods and "cut-off" dates for the ACPS periodic disability, death, and daily payrolls.

The production schedule for the DMS periodic reports is made available for the appropriate personnel. IT IS IMPERATIVE that this schedule be closely followed.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

FECA BULLETIN NO. 98-03

Issue Date: March 1, 1998

Expiration Date: February 28, 1999

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 1998.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 1998.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 1.5 percent.

2. The increase is effective March 1, 1998, and is applicable where disability or death occurred before March 1, 1997.

3. The new base month is December 1997.

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

$ 5,892.94 per month
1,359.91 per week
5,439.64 each four weeks
271.98 per day (for a 5-day week)

Applicability: Appropriate National Office and District Office personnel.

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

Action: On or about February 20, 1998, both the periodic disability and death payrolls will be updated in ACPS. If there are any cases with gross overrides, there will be no supplemental record created. Thus, the cases with gross overrides must be reviewed to determine if CPI adjustments are necessary. If adjustment is necessary, a manual calculation will be required.

1. Adjustment Dates.

a. As the effective date of the CPI is March 1, 1998 and the start date of the periodic and death payroll cycles is March 1, 1998, there will be no supplemental record created.

b. The CA-816, LWEC, program must be updated with the new CPI percentage. This update must be performed in each district office.

2. Adjustments of Daily Roll Payments. Since the CPI will not be in ACPS until February 20, 1998, daily roll payment cases requiring the new CPI should be held for data entry until that date.

3. CPI, Minimum and Maximum Adjustments Listings. Form CA-841, Cost-of-Living Adjustments; Form CA-842, Minimum Compensation Rates; and Form CA-843, Maximum Compensation Rates, should be updated with the new information. Attached to this directive is a complete list of all the CPI increases and effective dates since October 1, 1966 through March 1, 1998.

4. Forms.

a. Form CA-837, Notice to Payee, will be sent to the payees on the periodic disability and death payrolls. The notice will be sent to the payees from the National Office. The CA-837 will be addressed using the ACPS Correspondence Address File. PLEASE be sure to maintain the address file as you do with the Payee Address File and the CMF. PLEASE remember that an address change to the CMF DOES NOT automatically change the ACPS check address or correspondence address. ACPS must be accessed and the enter key must be depressed through the address areas. Be watchful for those payments being sent via Direct Deposit.

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

c. CP-140 will be printed for each case adjusted. These may be drop filed in the case file.

d. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification; insurance verification; loan application; etc., please provide this data in letter form from the district office. Many times the Form CA-837 does not reach the addressee; regeneration of the form is not possible, thus, a simple letter indicating the amount of compensation paid each four weeks will be adequate 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.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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

COST-OF-LIVING ADJUSTMENTS

Under 5 USC 8146a

EFFECTIVE DATE	RATE	EFFECTIVE DATE	RATE
10/01/66	12.5%	04/01/80	7.2%
01/01/68	3.7%	09/01/80	4.0%
12/01/68	4.0%	03/01/81	3.6%
09/01/69	4.4%	03/01/82	8.7%
06/01/70	4.4%	03/01/83	3.9%
03/01/71	4.0%	03/01/84	3.3%
05/01/72	3.9%	03/01/85	3.5%
06/01/73	4.8%	03/01/87	.7%
01/01/74	5.2%	03/01/88	4.5%
07/01/74	5.3%	03/01/89	4.4%
11/01/74	6.3%	03/01/90	4.5%
06/01/75	4.1%	03/01/91	6.1%
01/01/76	4.4%	03/01/92	2.8%
11/01/76	4.2%	03/01/93	2.9%
07/01/77	4.9%	03/01/94	2.5%
05/01/78	5.3%	03/01/95	2.7%
11/01/78	4.9%	03/01/96	2.5%
05/01/79	5.5%	03/01/97	3.3%
10/01/79	5.6%	03/01/98	1.5%

Prior to 09/07/74, the new compensation after adding the CPI is rounded to the nearest $1.00 on

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

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

FECA BULLETIN NO. 98-04

Issue Date: February 28, 1998

Expiration Date: February 27, 1999

Subject: Bill Payment/BPS - New Edits for Procedure Code Dates of Validity.

Background: Each year, the American Medical Association (AMA) revises the Physicians' Current Procedural Terminology (CPT) codes. The revised codes are generally effective the first day of each calendar year. The revisions usually include the deletion of certain codes, addition of others, and changes to the narrative description for some codes.

In the past, when AMA deleted a code, OWCP kept the code in the system for one year past the effective deletion date, to allow for payment of bills for the prior calendar year. After the year was over, the code was deleted.

Begin and end dates have been added to OWCP's procedure code file (v30). These begin and end dates are applicable to all procedure codes, not just the CPT procedure codes.

Three new edits using procedure code begin and end dates have been added to the bill editing program (BILL552), and are operational with the February 18 installation of the updated program.

Editing for procedure code dates of validity will allow offices to process bills using the procedure codes which were valid at the time the services were rendered, rather than having to substitute a currently valid code. In addition, it is anticipated that some charges which now suspend with edit 014 failures will either be paid or will be denied automatically with an appropriate EOB message.

Reference: Federal (FECA) Procedure Manual, Chapters 5-0200 and 5-0204.

Purpose: To advise office staff of new BPS edits which verify the validity of procedure codes for the dates of service billed.

Applicability: All bill resolution staff, contact representa- tives, claims examiners, supervisors,

and systems managers.

Action:

1. Detailed edit sheets for the three new edits are attached. The sheets explain each new edit, provide resolution instructions, if applicable, and provide other relevant information. These should be inserted in the appropriate place in the expanded bill resolution job aid.

2. In addition to these new edits, several new alternate EOB messages (900 series) have been added at the request of field personnel. The new EOB messages are as follows:

942 Billed service denied. Duplicate of service previously reimbursed to the injured employee.

(This message would be used when a medical provider or health insurance carrier claims payment, and the claimant has already been paid for the same services.)

943 Billed service denied. Duplicate of service previously paid to the medical provider.

(This message would be used when the claimant or a health insurance carrier claims payment, and the medical provider has already been paid for the same services.)

944 Billed service denied. Duplicate of service previously paid to another carrier.

(This message would be used when the claimant or the medical provider claims payment, and the health insurance carrier has already been paid for the same services.)

3. A complete listing of all EOB messages and a revised con- densed edit job aid has been made available under separate cover.

4. In working with these edits, resolvers must be aware of the potential for duplicate billing due to use of more than one procedure code for the same service.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

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

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 322L

ERROR DESCRIPTION: DATES OF SERVICE ARE PRIOR TO EFFECTIVE DATE OF THE PROCEDURE CODE

EDIT DESCRIPTION: TO DATE_OF_SERVICE IS PRIOR TO V30 BEGIN DATE FOR THIS PROCEDURE CODE

SUSPEND/DENY: S

OVERRIDE: Y

EOB: This procedure code did not become valid until after the dates of service. If services have not already been paid using another code, please rebill using a procedure code which was valid at the time services were rendered.

PRIORITY: 4

BILL RESOLUTION:

1. Verify accurate keying of procedure code and dates of service.
2. Check online history to ensure that charge has not already been paid using a different procedure code. If it has already been paid, set to deny with alternate EOB 933.
3. Check the begin date for the procedure code in question. If the billed service dates predate the begin date by only one or two months, or if the bill is an old (more than two years) one which is only now being processed because of delays in adjudication, the edit failure may be overridden. Otherwise, set to deny with EOB 322 (above).

February 18, 1998

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 323L

ERROR DESCRIPTION: PROCEDURE CODE NOT VALID FOR DATES OF SERVICE

EDIT DESCRIPTION: FROM DATE_OF_SERVICE IS AFTER V30 END DATE FOR THIS PROCEDURE CODE

SUSPEND/DENY: D

OVERRIDE: N

EOB: This procedure code was no longer valid as of the dates of service. If services have not already been paid using another code, please rebill using a code which is valid for the period of service.

PRIORITY: 4

BILL RESOLUTION:

N/A

February 18, 1998

MEDICAL BILL SYSTEM
EDITS

EDIT NO. 324L

ERROR DESCRIPTION: DATES OF SERVICE OVERLAP PERIOD PROCEDURE CODE WAS VALID

EDIT DESCRIPTION: PERIOD OF TIME REPRESENTED BY FROM/TO DATES_OF_SERVICE OVERLAPS V30 BEGIN/END DATE PERIOD BUT IS NOT WHOLLY CONTAINED WITHIN

SUSPEND/DENY: D

OVERRIDE: N

EOB: During a portion of the period covered by these dates of service, the procedure code was not valid. Please resubmit, breaking down the period of time further, using valid codes (and units) for each period of time.

PRIORITY: 4

BILL RESOLUTION: N/A

FECA BULLETIN NO. 98-05

Issue Date: March 5, 1998

Expiration Date: Indefinite

Subject: Bill Pay/BPS - Supervisory Sampling of Bills

Background: Recent reports from the Office of Inspector General cite numerous errors in bill processing. Some of these errors, such as failure to key procedure code modifiers, inaccurate units, overuse of bypass code 1, making payment to the wrong provider, misuse of authorizing initials, and incorrect dates of service, are due to inaccurate keying of bills. Other errors, such as inadequate authorization for bills over certain dollar limits, misuse of all bypass codes, and the failure to detect keying errors, are due to mistakes made in the bill resolution process.

FECA Bulletin 94-10, issued November 2, 1993, outlined revised procedures for supervisory sampling of bills. Recent accountability reviews have shown that some district offices are not carrying out regular supervisory sampling of bills.

It is critical that thorough supervisory sampling of bills be carried out on a regular basis, and that corrective actions be taken when problems are found.

A computer-based training package for keying bills is under development.

Reference: FECA Bulletin 94-10.

Purpose: To reissue and update procedures for supervisory sampling of bills.

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

Action:

1. Bills processed through the BPS will be sampled on a monthly basis by supervisory personnel.

2. By the tenth day of each quarter, the individuals performing the bill sampling will provide a report of the previous quarter's findings to the District Director, with proposed corrective actions, if needed. Consideration of corrective action must be given for any error detected.

3. A copy of the quarterly report (findings and corrective actions) will be provided via E-mail to the Director for FEC, with a copy to Sheila Williams, Deputy Director for FEC, no later than the 20th day of the quarter, along with a time table for the corrective actions.

4. Offices will perform two separate bill reviews: one of the physical batches; the other of individual bills. Work sheets and instructions for each type of review are attached.

5. For the batch review, 1% of the bill batches completed during the month will be reviewed. If 1% of the batches completed during a month exceeds 20 batches, then 20 batches will be reviewed. The batches should include work from all keyers and resolvers, if possible. This review will involve examination of the physical bill batches only, although further investigation

may be made, when indicated. Examples of situations warranting further review include: the presence of bill with no date stamp; or the presence of a bill on an incorrect form. During the batch review, the reviewer should also make note of bills with extended service date ranges, procedure code modifiers, multiple units, high dollar amounts, and repetitions of the same procedure code for the same date of service on the same bill, for inclusion in the bill reviews.

6. For the bill reviews, a minimum of 42 individual bills should be reviewed. The bills should not be selected randomly, but should include all keyers and resolvers, and as many different bill types as possible. Bills with extended service date ranges, procedure code modifiers, multiple units, high dollar amounts, and repetitions of the same procedure code for the same date of service, as identified during the batch review, must be included in the sample. If no such bills were found during the batch review, a reasonable effort should be made to identify bills of this nature from other bill batches. Both paid and denied bills should be selected, with at least 80% of the bills being paid bills. Overnight histories should be obtained for all of the paid bills, using specific provider identification numbers and dates of service to reduce the size of the report. The on-line bill payment history will be used to evaluate certain items. The BP40 report (Register of Miscellaneous Checks Paid) will also be used.

7. The purpose of these reviews is to ensure the accuracy, quality, and security of the bill processing operation. Therefore, more extensive reviews should be made if the initial findings indicate the potential for a problem.

8. Bills will also be reviewed using these procedures as part of the Accountability Review and Management Review processes.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 4--Folioviews Groups B and D (Fiscal Officers, Benefit Payroll Clerks and Assistants, All Supervisors, Systems Managers, Technical Assistants)

Attachment A1

INSTRUCTIONS FOR COMPLETION OF BILL SAMPLING WORKSHEET

Obtain a Central history for each paid bill being sampled. The Central history contains receive date, bypass codes, payee address, authorizing initials, units, and ineligible amounts and codes, which are not available in the on-line history. [Bypass codes and units are being added to on-line history.] The on-line history contains information on both paid and denied bills, including service dates, procedure codes, charge amounts, paid amounts, check date, EOB date, EOB numbers, and resolver ID. In addition, the on-line history displays information on bills which reject in the Central processing. The BP040 reports will also be needed.

Bill No. - The 9-digit bill number, which includes the 6-digit batch ID number and the 3-digit sequence of the bill within the batch.

Def.? - If any of the following items is found to be deficient, this box should be checked.

Approp. Form? - Was the form type appropriate for the provider type (HCFA-1500, UB-82, UB-92, etc.)? (Y/N)

Receive Date OK? - Is the receive date as stamped on the bill the same as the receive date entered on the system (as found in history)? (Y/N)

Keyed OK? - Compare the information found on the bill with the information found in history (note that service dates, procedure codes, and bypass codes are covered separately). Were the correct number of units keyed? If the bill was paid, examine the BP040 to determine whether the address on the bill matches the address to which payment was made. If the bill suspended, look at the BILL552 batch report to determine whether keying errors caused the bill to fail edits. Was the correct provider selected? (Y/N)

Auth. Amt.? - If the bill total was over the maximum for that provider type, does the bill show the initials of the authorizing individual, and are those initials in agreement with the authorizing initials in the history? (N/A, Y, or N)

Altered Charges? - Are any of the charge amounts on the bill different from the amounts on the history? If yes, were changes made to the bill, and are the changes justified? Ineligible amount codes and amounts should also be considered. (Y/N)

Service Dates OK? - Do the dates of service on the bill agree with the dates of service in the history? Be especially mindful of whether the dates on the bill reflect a single date, or a date range. (Y/N)

Bypass Codes OK? - Does the bill or history reflect use of bypass codes, and if so, were they used appropriately? (Bypass code 1 need not appear on the bill itself. Bypass codes 2 or 3 must be written on the bill. Note that if the bill was paid as the result of the bill resubmit program, the bypass code may be written on the duplicate bill report, rather than the original bill itself.) (N/A, Y, or N)

Proc. Codes - If procedure codes were required, were they used appropriately? Are the procedure codes on the bill in agreement with the procedure codes in the on-line history and the codes in history? Were procedure code modifiers present on the bill keyed? (N/A, Y, or N)

Adj. OK? - Whether the bill was paid, denied, partially paid/partially denied, or internally denied, was the adjudication of the bill correct? Case notes on the system, accepted conditions, or other information may need to be reviewed to answer this question. (Y/N)

EOB OK? - If the bill was denied, were the EOB messages that went to the biller appropriate? Review the on-line history to determine the EOB messages, and consult with the list of EOB messages to determine what they actually were. Note that if more than two EOB messages were used, only the two highest priority EOB messages will be recorded in the on-line history. The EOBs used should reflect the most appropriate message to the biller. (N/A, Y, or N)

Remarks - Any other irregularities about how the bill was processed should be noted here, including inaccurate units. If the bill rejected at Central, is there an adequate audit trail of the final disposition of the bill?

Attachment B1

INSTRUCTIONS FOR COMPLETION OF THE BATCH SAMPLING WORKSHEET

This review is to be based solely upon examination of the physical bill batches. For "tally" items, make a tally mark (/) for each bill in which there is an error with respect to the indicated area.

Batch No. - The 6-digit batch identification number.

No. of bills - The number of bills contained in this batch, as indicated on the CA-D-9 batch cover sheet. Does this number agree with the number indicated on the BILL552 report, and the actual number of bills physically present in the batch?

Case File # - Make a hash mark here if the case file number is not present on the bill.

Provider EIN - Make a hash mark here if provider EIN is not present on the bill. If bill is for pharmacy, travel, maintenance or training reimbursement to the claimant, no provider EIN is required.

Provider address - Make a hash mark here if full provider address is not present on the bill. No provider address is required if bill is for pharmacy, travel, maintenance or training reimbursement to the claimant.

Date stamp - Make a hash mark here if there are irregularities with respect to the date stamp. Irregularities would include no date stamp, or more than one date stamp with no indication that the bill had at some point been returned.

Form - Make a hash mark here if bill is not on an appropriate form.

Attachment A2 BILL SAMPLING WORKSHEET (Link to Image)

Attachment B2 BILL SAMPLING WORKSHEET (Link to Image)

FECA BULLETIN NO. 98-06

Issue Date: April 10, 1998

Expiration Date: April 9, 1999

Subject: Debt Collection: Referrals to the Department of Treasury.

Background: In April 1996, the Debt Collection Improvement Act of 1996 was passed. This Act mandates referral of debts to Federal agencies that are more than 180 days delinquent to the Department of Treasury for administrative offset. The Department of Treasury has designated the Financial Management Service (FMS) to oversee the two offset programs, cross-servicing and the Treasury Offset Program.

Cross-servicing makes the Department of Treasury responsible for all collection efforts. A variety of methods are used, from letter writing to salary offsets to, in some cases, referral to a private collection agency. Any debt referred for cross-servicing will also be handled under the Treasury Offset Program.

The Treasury Offset Program maintains a delinquent debtor database nationwide, and all federal payments disbursed by the FMS will be matched against this database for potential offset. The FMS may also refer debts to private collection agencies and may undertake other debt collection duties.

Under this system, debts will no longer be transferred to the National Office for referral directly to private collection agencies.

Purpose: To inform District Offices of the change in procedure for collection of delinquent debts and to advise of specific procedures to follow for referral for administrative offset.

Applicability: All claims and fiscal staff.

Action: Debt management will continue to be handled in its preliminary stages according to current procedure. Referral of debt for cross-servicing by FMS is only to occur when a debt is 180 days or more delinquent. Referral of debt to the Department of Treasury will replace referral to Private Collection Agencies as outlined in FECA PM 6-300.12.

District Offices must monitor all debts approaching or over 180 days delinquent for possible treasury referral, and must ready cases for such referral when needed.

1. When any debt is at least 90 days but not more than 120 days delinquent, the responsible Senior Claims Examiner should review the case to ensure that a letter outlining due process requirements for debt referral has been issued, and, if not, issue one. The letter must:

    a. Provide written notification of the nature and amount of the debt and of the Office's intention to collect the debt via administrative offset;

b. Give the debtor the opportunity to inspect the file for all records concerning the debt;
c. Note that the debtor has been given the opportunity to appeal the debt;
d. Note that the debtor has been given the opportunity to enter into a written repayment agreement;
e. State a specific contact name and note that the debt may be referred for litigation.

The current system-generated collection letters, Forms CA-9001 and CA-9002, have been amended to meet this requirement. Examples of these letters are attached as Exhibits 1 and 2.

2. Each month, District Office staff should review the DMS aging report and, for all debts turning 180 days old where the claimant has received proper notice as outlined above, complete the package shown at Exhibit 3 and forward this package to the attention of Sheila Baker in the National Office. A guide for completion of this form is attached as Exhibit 4. A copy of all letters and decisions concerning the debt, especially the due process letter, must be attached. Ms. Baker will request appropriate debts for transfer to District 90 under code 08, Treasury referral. No debt may be referred without National Office request.

3. The District Office may not refer debts that are:

a. In litigation or referred to the Justice Department;
b. Already with a private collection agency;
c. On appeal (this includes debts currently before the ECAB);
d. Covered by Bankruptcy.

4. The District Office must immediately stop all collection efforts. If an FMS request is made of the District Office, the National Office should be contacted immediately.

5. If a debtor contacts the District Office about the debt, only questions regarding the validity of the debt may be answered. Any questions concerning the amount due or debt balance must be referred to FMS at 202-874-6660.

Debts referred for cross-servicing will remain transferred to District 90 until they are closed or returned by FMS. The National Office will then review the debt and take appropriate action or return the debt to the District Office.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FB 98-06 Exhibit 1: CA-9001

File Number: 20001_010000001

Date of Injury: 03/01/1991

Employee: CLAIMANT NAME

CLAIMANT NAME

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Dear CLAIMANT NAME:

This letter is in further reference to your debt in the amount of $999,999.99, which resulted from the overpayment of benefits in your case. A copy of our final decision and first demand for payment, dated 01/01/1901, is enclosed. We have not received payment from you or any indication that you intend to cooperate in this matter.

If we do not receive payment, or some indication that you intend to make payment, within 30 days of the date of this letter, we may add the following charges to the debt:

1. Interest at the current rate of the U.S. Treasury Bill. It will begin to accrue as of the date of this letter.
   Interest charges will be waived if payment is received within 30 days.

2. Administrative charges for sending any additional demands for payment.

If necessary, the Office of Workers' Compensation Programs (OWCP) can ask a debtor's federal employing agency to recover an overpayment from the debtor's salary. OWCP can also ask the Office of Personnel Management to recover the overpayment from money payable to the debtor from the Civil Service Retirement Fund. If you do not send us a check or contact us about this debt within 30 days, and you work for the federal government or are eligible for or in receipt of a Civil Service annuity, we may pursue one of these courses of action.

Also, if your debt remains delinquent, we may refer it to the Department of the Treasury for collection by administrative offset from any federal payments which may be due you. We will assess an additional administrative cost to help defray the expense of this referral. Information about the status and delinquency of your debt is reportable to credit bureaus.

You have the following rights with respect to referral of your debt to the Department of the Treasury or to credit bureaus:

EXHIBIT 1 CA-9001, page 1

You may inspect and request copies of your records about this debt;

You may enter into a mutually agreeable written repayment agreement; and

You may request a review of our determinations about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

You are expected to reply within 30 days. Make your check payable to the U.S. Department of Labor, OWCP, and include your FECA file number on the check. Send payment to:

District Office Lockbox Address Line 1
District Office Lockbox Address Line 2
District Office Lockbox Address Line 3
District Office Lockbox Address Line 4
District Office Lockbox Address Line 5

If you wish to enter into a written repayment agreement, contact me immediately on 999-999-9999.

Sincerely,

NAME OF SIGNER
TITLE

Enclosure(s):

CA-9001, page 2

FB 98-06 Exhibit 2: CA-9002

File Number: 01_0000001

Date of Injury: 01/01/1901

Employee: CLAIMANT NAME

CLAIMANT NAME

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Dear CLAIMANT NAME:

This letter is in further reference to your debt in the amount of $999,999.99, which resulted from the overpayment of benefits in your case.

Because 30 days have passed and we have not received payment or an indication that you intent to repay this money, your debt is now considered to be delinquent. Interest will therefore be assessed at the rate which applied when you received your first notice of indebtedness, or 99%. Penalty charges of 6% per year for any portion of the debt remaining delinquent for more than 90 days and administrative charges may also be added.

We may refer the debt to a credit bureau and to the Department of the Treasury for administrative offset if payment is not made within 60 days of the date of this letter. Information which will be given to a credit bureau is limited to your name, address and Social Security Number; the amount, status and history of the debt; and the program under which the debt arose, that is, the Federal Employees' Compensation Program.

Once your debt has been referred to the Department of the Treasury, administrative charges will be added to the current principal amount. These charges, which are computed as a percentage of the debt, reflect our collection cost. They are authorized by the Debt Collection Improvement Act of 1996 (Public Law 104-134). This referral will therefore result in a large increase in the size of your debt.

You may avoid these outcomes by sending your check in the amount stated above. Make your check payable to the U.S. Department of Labor, OWCP, and include your FECA file number on the check. Send it to:

District Office Lockbox Address Line 1
District Office Lockbox Address Line 2

District Office Lockbox Address Line 3

District Office Lockbox Address Line 4

District Office Lockbox Address Line 5

EXHIBIT 2 CA-9002, page 1

As you have been advised previously, you have certain rights in with respect to referral of your debt to the Department of the Treasury or to credit bureaus:

You may inspect and request copies of your records about this debt;

You may enter into a mutually agreeable written repayment agreement; and

You may request a review of our determinations about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

If you wish to enter into a written repayment agreement, contact me immediately on 999-999-9999.

Sincerely,

NAME OF SIGNER
TITLE

CA-9002, page 2

FECA Bulletin 98-06 **Exhibit 3: Referral of Debt to Treasury for Offset**

(Link to Image) page 1-2
(Link to Image) page 3-4

FECA Bulletin 98-06 **Exhibit 4: Guide for Form Completion**

(Link to Image) page 1-2
(Link to Image) page 3

FECA BULLETIN NO. 98-07

Issue Date: January 5, 1998

Expiration Date: January 4, 1999

Subject: Compensation Pay: Compensation Rate Changes Effective January 1998.

Background: In December 1997, the President signed an Executive Order implementing a salary increase of 2.30 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only applies to the 2.30 percent increase in the basic General Schedule. Any additional increase for locality-based pay is excluded. The adjustment is effective the first pay period after January 1, 1998.

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

The new rates will be effective with the first compensation payroll period beginning on or after January 1, 1998. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $94,287 per annum.

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

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

Effective January 4, 1998	Minimum	Maximum
Monthly	$1,214.25	$5,892.94
Weekly	210.16	1,359.91
Daily(5-day week)	42.03	271.98

The basis for the minimum compensation rates is the salary of $14,571 per annum (GS-2, Step 1) and the basis for the maximum compensation rates is $94,287 per annum (GS-15, Step 10).

The effect on 5 U.S.C. 8133(e) is to increase the minimum monthly pay on which compensation for death is computed to $1,214.25, effective January 4, 1998. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $5,892.94 per month.

Applicability: Appropriate National and District Office personnel.

Reference: Memorandum For Directors of Personnel dated December 1997; and the attachment for the 1998 General Schedule.

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

1. Adjustments Dates.

   a. As the effective date of the adjustment is January 4, 1998, there will be no supplemental payroll necessary for the periodic disability and death payrolls.

   b. The new minimum/maximum compensation rates will be available in ACPS on or about January 23, 1998.

2. Adjustment of Daily Roll Payments. Since the salary adjustments are not retroactive, it is assumed that all Federal agencies will have ample time to receive and report the new pay rates on claims for compensation filed on or after January 1, 1998. Therefore, it will not be necessary to review any daily roll payments unless an inquiry is received. If an inquiry is received, verification of the pay rate must be secured from the employing establishment.

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

CA-842

1/04/98	42.03-63.05	210.16-315.24	42.03	210.16	1,214.25
	42.03-56.04	210.16-280.21			

CA-843

1/04/98	271.98	1,359.91	(5,439.64)	5,892.94

4. Forms. CP-150, Minimum/Maximum Compensation, will be generated for each case adjusted. Notices to payees receiving an adjustment in their compensation will be sent from the National Office. Form CA-839, Notice of Increase in Compensation Award, will be utilized for this purpose Manual adjustments necessary because of gross overrides should be made on Forms CA-24 or CA-25 with a notice sent to the payee by the District Office.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 98-08

Issue Date: March 24, 1998

Expiration Date: March 23, 1999

Subject: November 1997 DFEC/OPM Computer Match

Background: Another DFEC/OPM computer match, designed to identify possible occurrences of prohibited concurrent dual benefit payment, was completed last month using the data for the November 8, 1997 periodic roll cycle. The data shared with OPM again included the death roll,

and excluded schedule award cases. 74 cases survived the manual and automated screening processes employed by OPM. The last DFEC/OPM Computer Match was conducted in February, 1997.

With its advance copy of this bulletin, each District Office will receive a computer printout of the cases under its jurisdiction which should be screened, followed and reported on in accordance with the procedures described in FECA Bulletin 96-4 and again specified below. The presence of a case on the list should indicate that benefits were being paid by both DFEC and OPM on November 8, 1997, in apparent violation of the dual benefit prohibitions.

For this, and future matches, we will continue to follow the procedures used in the past; that is, OPM and the responsible District Offices will directly converse and correspond in order to resolve the hits. The District Offices will continue to have National Office reporting requirements, as detailed below. However, any problems that arise with OPM, or with any other aspect of processing the match hits, should be raised with Sheila Baker (202) 219-8461 for resolution. Telephone inquiries to OPM should be directed to Eugene Wooldridge at (202) 606-0228 (or 606-0228). Written inquiries or other correspondence should be directed to the Office of Personnel Management, Retirement Inspection Branch, P.O. Box 7174, Room 2309, Washington, D.C. 20044-7174, Attention: Eugene Wooldridge.

Purpose: To inform District Offices of the procedures for follow-up review and reporting requirements concerning the "hits" identified in the November, 1997 DFEC/OPM match, and to reiterate continuing reporting requirements for the previous OPM matches.

Applicability: District Directors, Assistant District Directors.

Action: Each District Office with one or more cases appearing as hits from this match will receive a copy of a computer printout detailing the information on those cases, in a combined listing of disability and death cases. (On this printout the OPM Claim Number begins with "A" for disability cases and begins with "F" for death cases. Also, if the first digit of the OPM Claim Number is 7 or 8 then benefits are being paid under FERS rather than CSRS.) In addition, individual "hit sheets" completed by OPM are in the process of being mailed directly to the District Offices by OPM. Please note that the field identified on the printouts as "OWCP Gross" is actually the FECA 28 day payment amount converted to a 30 day equivalent for easy comparison purposes. The "OWCP Net" field is the actual 28-day gross compensation amount paid.

1. Immediately pull and review each disability (OPM "A" prefix) case listed in which the OPM gross payment amount exceeds the FECA gross payment amount. (For these cases the OPM amount is underlined on the printout.) If a review of the case confirms that the claimant is, in fact, in receipt of prohibited dual benefits, then action should be taken immediately to obtain an election from the claimant. If the receipt of dual benefits was discovered as a result of this computer match, the claimant should be advised of this. The claimant should be advised that the benefit not elected will be terminated and that he or she may dispute the dual benefit finding and proposed action. The claimant will be given 30 days to complete and return an election of benefits form. Upon receipt of the completed election form, the benefit not elected is to be terminated as soon as possible. A copy of the election form is to be returned to OPM along with a copy of the supplemental "hit sheet." If the claimant fails to make an election or to dispute the dual benefit finding within the 30 day period, the claimant should be removed from the compensation rolls as soon as possible.

2. Review the remaining disability cases (those where FECA benefits exceed OPM benefits), and the death (OPM "F" prefix) cases (as detailed below). In the disability cases where FECA benefits are greater, OPM will seek the election and return a copy of the election along with a completed OPM "hit sheet" to DFEC.

3. In death/survivor cases (OPM "F" prefix), an informed election must be made before either benefit is terminated. Please remember that split elections can be made. In fact, several *de facto* split elections were discovered during previous matches; that is, there appeared to be dual benefits situations when in fact different beneficiaries were receiving OPM and FECA benefits. In other cases split elections have been made as a result of the matches. It is important that truly informed elections are made in these cases. During the 3rd match you were advised of our revised policy regarding the revocability of elections in death cases.

That change was formalized by revision to the regulations. However, OPM maintains that survivor elections are irrevocable; that is, that once an election of FECA benefits is made, the beneficiary may not subsequently elect OPM benefits, unless the FECA entitlement is later determined to have been mistaken, or there is a third-party credit absorption.

Therefore, included in the information provided to a beneficiary in order for him/her to make an informed election should be a statement that an election of OPM benefits can later be changed to elect FECA benefits, but that the reverse is not possible. In addition, an informed election should be based on a comparison of each beneficiary's benefits. Where the total converted gross FECA benefit is greater than the total OPM benefit, OPM will obtain the election of benefits and return a copy of the election along with a copy of the OPM "hit sheet" to DFEC.

Where the total OPM benefit exceeds the total converted gross FECA benefit and the review of the file confirms that the claimant is, in fact, in receipt of prohibited dual benefits, then action should be taken immediately to obtain an election from the claimant. If the receipt of dual benefits was discovered as a result of this computer match, the claimant should be advised of this. The claimant should be advised that the benefit not elected will be terminated and that he or she may dispute the dual benefit finding and proposed action. The claimant will be given 30 days to complete and return an election of benefits form. Upon receipt of the completed election form, the benefit not elected is to be terminated as soon as possible. A copy of the election form is to be returned to OPM along with a copy of the supplemental "hit sheet." If the claimant fails to make an election or to dispute the dual benefit finding within the 30 day period, the claimant should be removed from the compensation rolls as soon as possible.

4. In any case which results in a DFEC overpayment, the District Office should take immediate action in accordance with the overpayment procedures specified in Part 6 of the Procedure Manual.

5. Each DFEC overpayment case should be reviewed in order to determine whether the usual notifications concerning the prohibition against receiving concurrent retirement and compensation payments have been made. If so, the assumption must be made that the claimant is not without fault when such an overpayment occurs. Thus, except where this assumption is overcome by the evidence in the case file, a CA-2201 should be released immediately. Examiners are reminded that the supporting memorandum should explicitly detail the notification made.

6. When the appropriate overpayment letter is released, a 30-day call-up should be placed in the file. As soon as possible after a final decision has been released, administrative offset should be requested from OPM.

7. Initial review of all the listed cases should be completed and a report submitted by May 1, 1998 and quarterly thereafter until each "hit" is resolved. This review should confirm or refute the information supplied, the receipt of dual benefits and, where receipt of dual benefits is confirmed, determine whether or not there is an election of benefits on file. Each report must include, as appropriate:

a. The FECA case number and beneficiary name for each listing.

b. For death cases, the name, date of birth and relationship to the decedent should be listed for each eligible beneficiary.

c. Periods for which FECA benefits have been paid (specify schedule award periods).

d. Was the payment of dual benefits discovered through this match? (yes/no)

e. Is there an election on file? (yes/no) If yes, a copy of the election letter should be attached.

f. Have compensation payments been terminated? If so, effective on what date?

g. Is there an overpayment of compensation? (yes/no)

h. Is DFEC responsible for recovery?

i. What is the amount of the OPM overpayment?

j. What is the amount of the FECA overpayment transferred to the Accounts Receivable ledger?

k. Dates of subsequent due process and collection actions, including issuance of overpayment letters, final decision, release of SF-2805 to OPM requesting offset, etc. (Note: The current version of the SF-2805, Revised October 1988, should be used.)

Follow-up reporting for this match and for unresolved cases from prior matches should continue quarterly (by the 15th day of the first month of each quarter, i.e., 7/15, 10/15, 1/15, 4/15) until final resolution of the matter, until, for example, either the debt has been collected in full, a repayment schedule has been established and met at least once, or the account is otherwise closed. The final report should describe the repayment plan and/or date of payment. For example, the final report should show that a CA-2201 was issued on July 7, 1998; a final

decision was issued on August 11, 1998 finding an overpayment of $2000; an SF-2805 was issued on September 22, 1998; the first payment of $200 was received from OPM on December 1, 1998; the debt will be recovered by October 1999. (Note: For OPM debts, reporting may cease once the OPM overpayment amount has been reported. You no longer need to report any actions on OPM debts beyond this point.)

Disposition: This Bulletin should be retained until all actions have been completed.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Distribution: List No. 6
(Regional Directors, District Directors, Assistant District Directors, Chiefs of Operations, Systems Managers, Technical Assistants and National Office Staff)

FECA BULLETIN NO. 98-09

Issue Date: June 5, 1998

Expiration Date: June 6, 1999

Subject: Performance of Duty--Alternative Worksites

Background: For some time now, federal agencies have experimented with programs which allow employees to work from locations other than the federal agency's premises. Such locations include "satellite" offices in outlying areas as well as individual employees' homes. The performance of duty issues with respect to "satellite" offices are straightforward, since these sites are in fact regular offices, though employees from a variety of agencies may work there. However, for employees working at home, performance of duty issues are less clear.

While OWCP has received very few claims from employees in such programs (sometimes called "telecommuting" or "flexiplace"), we anticipate more in the future due to the growth of such programs, and we need to ensure that such claims are handled uniformly in all district offices.

Purpose: To provide guidance for determining whether employees injured while working at alternative worksites meet the "performance of duty" criterion for coverage under the FECA

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Rehabilitation Specialists, Staff Nurses, and Technical Assistants

Actions:

1. Employees who are directly engaged in performing the duties of their jobs are covered by the FECA, regardless of whether the work is performed on the agency's premises or at an alternative worksite. There is no statement (such as a "safety checklist") that can be signed by the employee to negate this coverage. As always, any affirmative defense of "willful misconduct" must be substantiated by evidence that the employee disobeyed an order that was routinely enforced.

2. However, when an employee is on property under his or her own control, activities which are not immediately directed toward the actual performance of regular duties do not arise out of employment. An employee who works at a desk at home removes himself or herself from the performance of regular duties as soon

as he or she walks away from that desk to use the bathroom, get a cup of coffee, or seek fresh air. The "Personal Comfort Doctrine" does not apply, and coverage cannot be extended for injuries which result from such activities.

This point is illustrated by two actual cases:

a. An employee (who already used a wheelchair) was injured when he reached to answer the telephone while working at home. Coverage was found because he was required to answer the telephone as part of his official duties.

b. An employee was injured while walking downstairs at home to check her furnace, which was malfunctioning. Maintenance of the furnace was not a requirement of her official duties. Once she left her immediate work area, she removed herself from coverage under the FECA.

3. By extension of the rule described in item 2, a chronic illness that developed due to environmental exposure at home would not be covered under the FECA. The environment in an employee's home is not under the employer's control, and the "premises rule" that applies when an employee is on property owned or maintained by the employer is not relevant. The employee would be exposed to the home environment whether working for the government or not. Therefore, he or she would not be exposed to any risk inherent to employment while working at home.

4. Apart from alternative worksite programs, an employer may allow an employee who is recuperating from an illness to perform work at home. If the illness has resulted from a work-related injury, the work performed at home may be a light-duty job. The effect on workers' compensation benefits of returning to work at home is no different from that of returning to any other light-duty job. The employee is entitled to compensation for any loss of wage-earning capacity resulting from a compensable injury.

5. If an employee cannot continue to work at home because of injury-related residuals, he or she is entitled to compensation. This situation is no different from that of an employee who attempts to return to light duty on the employer's premises.

6. If an employee cannot continue to work at home because the home environment is not conducive to performance of his or her duties, the situation represents a withdrawal of light duty, since an employer cannot usually dictate an employee's home environment or require an employee to use personal resources to perform official duties.

7. If the employer can no longer provide the employee with work at home, the situation represents a withdrawal of light duty.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 98-10

Issue Date: June 29, 1998

Expiration Date: June 28, 1999

Subject: Bill Payment/BPS - Preparations for Changes to Pharmacy Bill Processing

Background: On approximately July 15, 1998, systems changes will be put in place which will change the way pharmacy bills are processed. These changes involve new forms and data requirements.

Currently, when a pharmacy bill is processed as a reimbursement to the claimant, it is not necessary to enter any of the provider information into the system. In some offices, particularly those in the eastern regions, a large proportion of pharmacy bills are submitted as claimant reimbursements. As a result, entries for many pharmacies in those areas are not present on the district office provider files.

When the changes go into place, provider information will be required on all pharmacy bills. The National Office is mailing notices to both claimants and pharmacies, to advise them of the upcoming changes. Copies of the letters which are being released are shown as Attachment 1 and Attachment 2. However, it is difficult to disseminate the information to the pharmacies involved in the claimant reimbursements, since payments have not been made directly to them, and they are not on the provider files.

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

Purpose: To notify District Offices of changes in billing form requirements, and to provide instructions for adding pharmacy providers to the provider files.

Applicability: All staff.

Action:

1. Effective immediately, the Universal Claim Form (see Attachment 3) is an acceptable form for submission of pharmacy bills. The form is not required until July 15, 1998. Note that there are different versions of the form, all of which are acceptable.

2. Effective immediately, the Form CA-915 (Attachment 4) may be used for claimant reimbursements, except for travel. The CA-915 is to be used along with the form required according to the provider type, i.e., HCFA-1500 for physicians, UB-92 for hospitals, Universal Billing Form for pharmacies, etc. The CA-915 is not a required form.

3. Effective immediately, when a claim for pharmacy reimbursement from a claimant is received, the following steps should be taken:

a. Perform a provider inquiry (option 08, FECS001 Query Menu), to determine whether the pharmacy is on the provider file. To do this, the tax identification number and zip code will be needed.

b. If the provider is already on the provider file, the bill should be processed as it usually would be.

c. If the provider is not on the provider file, the bill should be forwarded to the secure provider file update individual(s) for addition of the pharmacy to the provider file. This can be done either before or after the bill is keyed.

d. If 50 pharmacy bills are checked in this way and all of the pharmacies are on the provider file, it is not necessary to screen any more bills.

e. If the office finds that pharmacies are not on the provider file, they should continue to screen incoming pharmacy reimbursements, and update the provider file, until the volume of pharmacies not on the file has diminished to no more than one in ten of those screened.

f. Care should be taken in making provider file updates, that duplicate entries are not made.

4. Whenever a pharmacy provider (provider type F) is added to the provider file between June 8, 1998 and July 15, 1998, a copy of Attachment 1, “Important Notice for Pharmacy Providers” should be sent to the provider.

The National Office will be monitoring additions of pharmacy providers to the provider file.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA Bulletin 98-10 Attachment 1

NOTICE: NEW REQUIREMENTS FOR PHARMACY BILLS

This notice applies to medical bill payments made by the Office of Workers' Compensation Programs (OWCP), under the Federal Employees Compensation Act (FECA).

EFFECTIVE JULY 15, 1998 - NEW FORMS AND CODES

- **Universal Billing Form** will be required for all pharmacy bills, even for reimbursement to the injured employee. The form is to be completed by the pharmacy. A copy of the form is attached for your reference.

- For reimbursement to injured employees, a **Form CA-915**, claimant reimbursement form, will be preferred. This form is used **in addition to** the Universal Billing Form. A copy of the CA-915 form is attached.

- All claims for prescription payments must be coded using National Drug Council (NDC) codes, and also contain the prescription number, refill number, decimal quantity, date filled, and the tax identification number and full name and address of the pharmacy.

- Bills not submitted properly will be returned or denied.

EFFECTIVE JULY 15, 1998 - ELECTRONIC BILLING

- OWCP will be able to receive pharmacy bills from pharmacy providers electronically by electronic data interchange (EDI).

WHAT DOES THIS MEAN FOR THE FECA BENEFICIARY?

- Pharmacy bills will be processed faster.

- Direct billings from pharmacies involve less paperwork than reimbursements to injured employees. If your pharmacy is not already billing OWCP directly for medications prescribed for your work-related conditions, you may wish to discuss this matter with them. Many pharmacies are willing to bill OWCP directly.

- Electronic billing by pharmacies will eliminate paperwork, and be processed faster.

- You may begin to use the new forms immediately.

Pharmacies are also being sent information about these changes. You may wish to discuss these changes with your pharmacy. Pharmacies wishing to bill electronically should contact their clearinghouse.

FECA Bulletin 98-10 Attachment 1

FECA Bulletin 98-10 Attachment 2

IMPORTANT NOTICE FOR PHARMACY PROVIDERS

This notice applies to medical bill payments made by the Office of Workers' Compensation Programs (OWCP), under the Federal Employees Compensation Act (FECA), which provides workers' compensation coverage for civilian employees of the Federal government.

NEW FORMS AND CODING REQUIREMENTS - EFFECTIVE JULY 15, 1998

- **Universal Billing Form** will be required for all pharmacy bills, and is to be completed by the pharmacy.
- All claims for prescription payments must be coded using National Drug Council (NDC) codes, and also contain the prescription number, refill number, decimal quantity, date filled, and the tax identification number and full name and address of the pharmacy.
- Bills not submitted properly will be returned or denied.

ELECTRONIC BILLING - EFFECTIVE JULY 15, 1998

- OWCP will be able to receive pharmacy bills from pharmacy providers electronically by electronic data interchange (EDI).
- Contact your EDI clearinghouse for further information.

WHAT DOES THIS MEAN FOR PHARMACY PROVIDERS?

- Pharmacy bills will be processed faster.
- Electronic billing by pharmacies will eliminate paperwork, and thus be processed even faster.
- You may begin to use the Universal Claim Form immediately, if you do not already.
- If you do not routinely bill OWCP directly for pharmacy services, begin doing so.

Injured employees prefer to do business with pharmacies which perform direct billing.

FECA Bulletin 98-10 Attachment 2

FECA Bulletin 98-10 **Attachment 3**

Drug Claim Form

(Link to Image) page 1

FECA Bulletin 98-10 **Attachment 4**

Claimant Medical Reimbursement Form

(Link to Image) page 1-2

FECA BULLETIN NO. 98-11

Issue Date: July 30, 1998___

Expiration Date: July 29, 1999

Subject: Bill Payment/BPS - Bill Processing Modifications

Background: On approximately August 4, 1998, systems changes will be activated to encompass changes in several different areas.

Several data elements have been added for pharmacy bills (provider type F), to allow more complete automated editing, and to prepare for a pharmacy fee schedule. Many of the ADP programs have been modified and new programs added to accommodate these changes in pharmacy bills.

DFEC will start to receive and process bills received via electronic data interchange (EDI). Pharmacy bills will be the first bills received in this manner.

A standardized billing form is required as of July 15, 1998 for paper pharmacy bills (see FECA Bulletin 98-10). Bills not on the required form need to be returned for resubmission. In the past, a manual system has been used to return bills (sometimes referred to as "send-backs"). Often, no record of having received the bill was kept. Returned bill log and letter generation programs

have been created to handle returned pharmacy bills. These programs should be used beginning July 22, 1998.

Bills received from vocational rehabilitation counselors (provider type U) will be coded using new DOL codes. In addition, rehabilitation services will be subject to editing based on authorized periods of service and authorized dollar amounts placed on the system.

Automated editing for nurse services will also be performed, using authorization parameters placed on the system.

These procedures are in effect for any bills processed after the installation of the changes. The procedures for returning pharmacy bills not on the correct for are in effect as of July 22, 1998.

Reference: Federal (FECA) Procedure Manual Chapters 5-0200, 5-0201, 5-0202, 5-0203, 5-0204, and 5-0205, FECA Bulletin 98-10, OWCP Bulletin 98-1.

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

Applicability: All staff.

Actions:

A. Pharmacy Bills

1. Several new data elements are being used, most of which will be present on the pharmacy bill:

a. NDC code - National Drug Council code - an 11-digit code which represents a specific medication, made by a specific manufacturer, of a certain strength. A medication which is known by name, such as Tylenol (which comes in both prescription and non-prescription forms), may have several different NDC codes associated with it (211 in this instance). NDC codes are assigned by the National Drug Council.

b. Prescription number - a number of up to seven digits which is assigned to a prescription by the pharmacy. Most prescription numbers are six digits.

c. Refill number - a two-digit code which describes whether the medication was dispensed as a new prescription or as a refill of a previous prescription. Refill numbers go from 00 (new prescription) to 99 (99th refill).

d. Quantity - similar to units, but may be expressed as a decimal fraction for liquids. For pills or capsules, the quantity will be the number of pills dispensed. For liquids, quantity will be

the volume dispensed, in milliliters (ml). For packaged items, such as aerosols or dose vials, the quantity is the number of packages. A quantity of eight digits is allowed for pharmaceuticals, five before the decimal point, and three after.

e. Prescriber ID - the last name of the physician who prescribed the medication.

2. As noted in FECA Bulletin 98-10, the tax identification number of the pharmacy is required for all pharmacy bills (provider type F), whether for direct payment to the pharmacy or reimbursement to the claimant.

3. New edits have been added to BILL552 to use the new data elements. These edits are summarized on pages 9-10. Complete bill resolution instructions for each new edit are being sent under separate cover, to be incorporated in the bill resolution job aid. These new pharmacy edits include editing for NDC code validity, and relationship of the medication to the accepted conditions in the case.

4. A therapeutic class (TC) code is associated with each NDC code. Therapeutic classes form fairly broad groupings. The relationship editing performed for pharmacy bills is based on the TC. Because NDC codes and their associated TCs change frequently (updates will be made monthly), a printed reference manual for prescription drugs is not practical. Two new query options have been added to both the FECS001 bill payment and query menus, for “NDC Query” and “Therapeutic Query” (see Paragraph C on page 5).

5. Duplicate checking for pharmacy bills is based upon case number, tax ID number, dates of service, prescription number and refill number. To prevent duplicate payments, it is critical that prescription numbers be data entered accurately.

6. Not all pharmacy charges that are submitted by pharmacies and claimants are for prescription drugs. Pharmacies also submit bills for over-the counter medications, supplies, durable medical equipment, and in some jurisdictions, taxes. Charges for over-the-counter medications, durable medical equipment, and supplies provided by pharmacies may be paid if they are prescribed (recommended) by a qualified physician for treatment of the work-related condition(s). Most over-the-counter medications do have NDC codes, but these may be difficult to obtain. Codes have been developed to accommodate non-prescription items. These codes are not to be used to process prescription drugs. They will be keyed in place of an NDC code, and should not have prescription or refill numbers. The codes must be shown on the bill. The codes are for Department of Labor use only, not for provider use.

DME - for durable medical equipment, such as a back brace
SUPPLY - for other supplies, such as ace bandages
OTC - for over-the-counter drugs for which an NDC is not available
TAXES - for taxes charged and billed. See FECA Circular 97-06. Most jurisdictions do not tax prescriptions.

7. Personnel should not attempt to provide NDC codes on behalf of pharmacies who submit bills without the codes.

B. EDI - Electronic Data Interchange (Pharmacy Only)

1. DFEC will receive and process electronic bills from pharmacies for prescription drugs only. These bills will be processed through intermediary clearinghouses. The bills will come into a central location in the National Office, go through some preliminary editing, primarily for validity of the case file number, and then be transmitted to the appropriate district office, where they will be loaded automatically into the bill tables. Electronic bills will exist only on the system.

2. A batch number assignment scheme has been developed for EDI pharmacy bills, as follows:

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

3. Once the EDI bills are loaded into the bill tables on the Sequent, they will be edited by the system, similarly to paper bills that are data entered into the system.

4. BILL552 reports will be produced for the EDI batches (along with the keyed bills). The suspended bills will require resolution, in accordance with existing procedures.

5. Because EDI bills are submitted electronically, ability to change the data submitted is very limited. In bill resolution, the only data fields which may be accessed are those which contain data which is provided by DFEC, such as authorizing initials, bypass codes, ineligible amounts and ineligible codes, rx appeal code, and bill total (to be changed only when ineligible amounts and codes are used).

6. Billing addresses for EDI pharmacy bills are obtained from a central location, rather than the district office provider file. The address sequence number for EDI bills will be FD if the bill is for direct payment, and FR if the bill is for claimant reimbursement.

C. NDC Query and Therapeutic Class Query

1. Two new options have been added to the FECS001 bill payment and query menus. In the bill payment menu, Option 22 is NDC query, and option 21 is therapeutic (class) query.

2. Each NDC code is assigned a therapeutic class (TC) code. The TC code consists of 10 digits. The TC coding structure is hierarchical, in that the meaning of the digits becomes more specific, from left to right. The first two digits are the "Main Therapeutic Heading;" the second two, the "First Subcategory;" the third two, the "Second Subcategory;" and the last four, the "Unique or Primary Agent." For example, for the TC code 2404080020, the 24 represents "Cardiovascular Agents", the 04 represents "Cardiac Drugs", the 08 represents "Cardiac Glycosides", and the 0020 represents "Digitalis". All of these category descriptions are shown when a particular NDC or TC code is entered in the programs.

3. A print of the NDC code query screen and instructions for use are shown in Attachment 1.

4. A print of the TC query screen and instructions for use are shown in Attachment 2.

5. Pharmacies are required to bill using NDC codes. If the product name is not also provided (it is not required), NDC query can be used to determine the name and nature of the medication.

6. For both NDC and TC query, the relationships between the drug and diagnosed conditions (by ICD-9 codes) are shown in ranges in the lower half of the screen.

D. Returned Pharmacy Bill Logging and Letters

1. A new option 23, “Returned Bill Log Entry” has been added to the FECS001 bill payment menu.

2. When a pharmacy bill is being returned because it is not on the correct form (Universal Billing Form or reasonably similar form), whether for direct payment to the provider or reimbursement to the claimant, the bill should be entered on the “returned bill log” by designated personnel. The data entered includes:

a. Case Number
b. First three letters of claimant’s last name
c. Direct payment flag (Y if provider is claiming payment, N if claimant is claiming reimbursement)
d. Provider tax ID number (required for direct payment; not required if claimant reimbursement, but should be entered if present)
e. Provider zip code
f. Provider sequence number (or cycle through)
g. Address OK? Flag for provider if direct pay, for claimant if not direct pay
h. Date bill received
i. Bill amount
j. Bill dates of service
k. A final OK? Prompt

3. A sequential serial number is assigned to each bill logged, which appears on the printed letter (see below).

4. Each day when returned bills are logged, BILL662 in the FECS002 Bill Payment menu should be run to generate cover letters for the returned bills. Attachment 3 shows a sample letter for pharmacy providers, and Attachment 4 shows a sample letter for claimants. The direct payment flag determines whether the letter is directed to the pharmacy or to the claimant. The letters will be printed in the order they were entered on the system. The bills being returned should be associated with the corresponding letter. The bills should then be mailed, using window envelopes.

5. Option 24, “Returned Bill Log Update” can be used to correct the date received, bill amount, or service from and to dates for a particular record, or to delete particular records. This option can also be used to query for returned bills on a particular case.

E. Changes to the Bill Payment Input Program

1. The bill payment input program is option 01 in the FECS001 bill payment menu.

2. The FECS user guide for the bill payment input program has been updated to include all of the changes, and is being provided under separate cover. A description of how the program has changed will accompany the user guide revision.

F. Changes to the Bill Resolution and Suspended Bill Query Screens

1. Bill resolution is option 10 under the FECS001 bill payment menu. Suspended bill query is option 18 under the FECS001 query menu and option 13 under the bill payment menu.

2. For EDI bills, access to the data fields under bill resolution will be limited as noted above in item B.5.

3. In the header screen, NABP, and PCC have been added. These are elements which apply only to EDI pharmacy bills, and are displayed for information purposes only. NABP is a unique identification number assigned to a pharmacy by the National Council of Pharmacy Drug Providers (NCPDP). PCC is a code identifying the payment cost center. This is used when more than one pharmacy uses a centralized payment center. For non-direct payments, "PHRM" has been removed from the label for the "PHRM/TRVL/MNT/TRNG REIMB:" flag, so that it now reads "TRVL/MNT/TRNG REIMB:".

4. In the line item screen, NDC, rx (prescription) number, refill number, prescriber, and rx appeal have been added. These are used for pharmacy bills only. For bills keyed in the office, the user will be able to correct these fields in bill resolution. For EDI bills, the user will not be able to alter these fields. In addition, the organization of the data on the screen has been modified to group all of the pharmacy elements together, and all of the non-pharmacy elements together.

G. Vocational Rehabilitation Services

1. Procedure codes are required for vocational rehabilitation counselor services (provider type U). Bills for provider type U cannot be paid without the codes. The codes are shown in Attachment 5.

2. A rehabilitation authorization program has been added to the FECS001 case management menu as option 39. The purpose of this new program was described in OWCP Bulletin 98-1, and instructions for use are found in Attachment 6.

3. Provider type U, V and W bills will be edited for dates of service being within the authorized period. Provider type U bills will be edited for total dollars not exceeding the amount authorized. These edits are summarized on pages 9-10. Full resolution instructions are provided under separate cover.

H. Contract Nurse Services

1. A nurse authorization program has been added to the FECS001 case management menu as option 40. When contract nurse services are authorized, the program should be accessed, and the authorized dates of service and the total maximum dollar amount authorized should be entered. Up to two date ranges for periods of authorization may be entered. Each authorization period may also be modified.

2. Access to the nurse authorization function should be limited to those individuals who authorize the services, or who have been given responsibility for entering authorizations from written documentation of the authorization.

3. New edits have been added for dates of service being within the authorized periods of time and total nurse costs being less than the dollar amount authorized. These edits are summarized on page 9. Use of the program is described in Attachment 7. Detailed procedures are being issued as an OWCP Bulletin.

I. Summary of New and Revised Edits

1. A package including an updated condensed edit listing, and EOB listing is being provided under separate cover.

2. Detailed edit sheets for all of the new edits are also being provided under separate cover. These should be inserted in the appropriate place in the bill resolution job aid.

The new and revised edits include the following:

201 - This is an existing edit for excluded providers. It has been modified to look for a record on the excluded provider file with a matching tax ID number if the bill is an EDI bill.

202 - This is an existing edit for providers suspended by the district office. The bill resolution instructions only have been changed, since for EDI bills, the tax ID number will not be keyed by DFEC.

314 - For pharmacy bills, edits for missing or invalid NDC code.

330 - For non-pharmacy bills, edit for decimal fraction units.

331 - For pharmacy bills, NDC code of TAXES has been used.

332 - For pharmacy bills, particular NDC code requires a manual review.

333 - For pharmacy bills, particular NDC code is not payable.

509 - For contract nurse bills, dollar total of nursing services exceeds the authorized dollar amount.

510 - For contract nurse bills, nursing services were not authorized.

520 - For contract nurse bills, dates of service on the bill are outside of the period of time authorized.

531 - For pharmacy bills, a code of DME, SUPPLY, or OTC was used, and the charge amount is greater than $25.00.

609 - For provider type U, dollar total of counselor services exceeds the authorized dollar amount.

610 - For provider types U, V, and W, services were not authorized.

620 - For provider types U, V, and W, dates of service on the bill are outside the period of time authorized.

734 - For pharmacy bills - therapeutic class is not payable for the accepted condition(s).

738 - For pharmacy bills, the relationship between the therapeutic class and the accepted condition(s) requires manual review.

744 - For pharmacy bills, there is an error in the range relationship table (this is an internal error, not a provider error).

746 - For pharmacy bills, the accepted condition is missing from the relationship table (this is an internal error, not a provider error).

Training on these procedures should be completed prior to
August 4, 1998.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

Attachments:
1 NDC Code Query
2 Therapeutic Query
3 Pharmacy Bill Return Letter
4 Claimant Pharmacy Reimbursement Return Letter
5 Vocational Rehabilitation Codes
6 Rehabilitation Authorization
7 Contract Nurse Authorization

Separate packages:
New edit sheets

Update of user guide for BILL051
Condensed edits and EOB messages

Attachment 1 National Drug Code Query (Link to Image)

Attachment 2 Therapeutic Class Query (Link to Image)

Attachment 3   Pharmacy Bill Return Letter

U.S. DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS
200 CONSTITUTION AVENUE
WASHINGTON DC 20001

DATE: 07/09/1998

ANDERSON DRUG STORE

100 HILL DR

BUILDING F

ROOM #1234

BALTIMORE MD 20750

RE: CLAIMANT NAME	OWCP CLAIM NUMBER
JOHN SMITH	01-0111111

DATE RECEIVED	SERVICE DATES	BILL AMOUNT
06/26/1998	05/26/1998-05/26/1998	27.00

Dear Pharmacy Provider:

The attached bill, which claims payment for medical services provided to an injured employee under the Federal Employees' Compensation Act (FECA), is being returned to you for the following reason:

Claims for prescription drugs must be submitted on the Universal Drug Claim Form, and include the following elements:

1. Your full name and address
2. Your Federal tax identification number
3. The injured employee's name
4. The injured employee's OWCP claim number (shown above)
5. The prescribing physician's last name
6. National Drug Code (NDC) for each medication
7. Date each prescription was filled
8. Each prescription number and refill number
9. Quantity of each medication dispensed
10. Charge for each item
11. Total charge

Please resubmit your bill in accordance with the above instructions or via EDI (Electronic Data Interchange).

Thank you for your cooperation.

Attachment 4 Claimant Pharmacy Reimbursement Return Letter

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS

200 CONSTITUTION AVENUE

WASHINGTON DC 20001

DATE: 07/09/1998

JANE DOE

300 MAIN STREET

GAITHERSBURG MD 20878

RE: OWCP CLAIM NUMBER PROVIDER NAME

02-0222222 CORNER DRUG STORE

DATE RECEIVED	SERVICE DATES	BILL AMOUNT
07/06/1998	06/20/1998-06/20/1998	$300.00

Dear FECA Claimant:

The attached bill, in which you claim reimbursement for pharmacy services provided under the Federal Employees' Compensation Act (FECA), is being returned to you for the following reason:

Claims for prescription drugs, whether for direct payment to the pharmacy or reimbursement to the employee, must be submitted on the universal Drug Claim Form. Your pharmacy should have this form and can complete it for you. The following information must be included on the forms:

1. Pharmacy's full name and address
2. Pharmacy's Federal tax identification number
3. The injured employee's name
4. The injured employee's OWCP claim number
5. The prescribing physician's last name
6. National Drug Code (NDC) for each medication
7. Date each prescription was filled
8. Each prescription number and refill number
9. Quantity of each medication dispensed
10. Charge for each item
11. Total charge

In addition, for reimbursement, proof of purchase, such as an itemized and dated receipt

or a canceled check, is needed. You may wish to use form CA-915 (copy attached) to help organize your reimbursement claim.

Please resubmit your claim in accordance with the above instructions.

Thank you for your cooperation.

Attachment 5

VOCATIONAL REHABILITATION CODES

Required for payment of rehabilitation counselor services.

Code	Description
VR001	Professional time of RC, per hour - counseling, placement, monitoring, testing, transferable skills analysis,job seeking skills training - prior authorization required
VR002	Non-professional time, by RC, or clerk/typist under the RC's supervision, per hour - travel, waiting - prior authorization required
VR003	Testing or transferable skills analysis performed by other than RC (when RC has paid the vendor and submits to OWCP original receipt and bill for reimbursement) - prior authorization required
VR004	Mileage associated with all travel - prior authorization required
VR018	Long distance telephone calls, Parking, Tolls and other Itemized Expenses

Attachment 6 Rehabilitation Authorization (Link to Image)

Attachment 7 Contract Nurse Authorization (Link to Image)

FECA BULLETIN NO. 98-12

Issue Date: September 21, 1998

Expiration Date: September 20, 1999

Subject: Codes--New QCM Code in Cases Where Claimant is Reemployed in Unclassified Job

Background: QCM procedures call for returning claimants to full time full duty wherever possible. This approach benefits both claimants and employing agencies, which can free up light duty positions for newly injured employees. Since the QCM procedures have been in effect, we have consistently urged claims staff to be vigilant with respect to claimants who are working only part time and/or at less than full duty, and to work toward returning such employees to full employment.

At the same time, the requirements for rating a claimant for LWEC have evolved in light of a group of cases from the Mare Island Naval Shipyard in California. Certain injured workers had been accommodated in light duty positions but were at risk from an impending RIF. A generic Industrial Trainee position was developed as transitional work leading to classified jobs. OWCP adjusted compensation based on the claimants' actual earnings while they participated in the program, but formal LWEC decisions were usually not issued. When a RIF in fact occurred, the targeted jobs were found to reasonably represent the claimants' WECs. However, the Branch of Hearings and Review properly found that claimants not actually reemployed in classified jobs could not be issued formal LWEC decisions.

These two developments have converged in certain cases where a claimant is reemployed in an unclassified job, either full or part time, with no indication that the hours or duties will increase. Such cases have had the benefit of QCM intervention, and no further QCM actions are necessary or feasible. Because their jobs are unclassified, the claimants must continue to be paid on the

basis of actual earnings for the indefinite future. The current QCM coding scheme contains no code which properly addresses the status of such cases.

References: A description of QCM codes is found in PM 2-601.5, while the criteria for resolution of QCM cases are found in PM 2-600.12. Actual earnings ratings are addressed in PM 2-814.7.

Purpose: To discuss the use of a new QCM code in cases where the claimant is working in an unclassified job

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Rehabilitation Specialists, Staff Nurses, and Technical Assistants

Action:

1. A new QCM code, CNC [Closed - RTW (No LWEC; Non-Classified Position)], may be used when a claimant is working full time in an unclassified job. The code is not appropriate in cases where the claimant is working only part time, as such cases will still require additional QCM attention.

2. Cases coded CNC will show as resolutions on the CASE611 report. However, QCM status codes may continue to be entered as appropriate after the effective date of the CNC code.
3. A subsequent closure status must be entered if a formal decision is issued in the case, or if the claimant returns to the date of injury position or suffers a recurrence or new injury.

4. The CASE611 detail report will list those cases that are coded CNC with no subsequent closure code. Claims staff will need to reexamine each case in CNC status during the QCM tracking period, and at periodic intervals thereafter if necessary, to assess the employability of the claimant in a classified job and the feasibility of issuing a formal LWEC decision.

5. District office managers are responsible for ensuring that follow-up action is taken on any cases remaining in CNC status at the end of the QCM tracking period.

6. Code CNC is available for use effective immediately.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

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FC 98-02 Revised Forms CA-1, CA-2, CA-5, CA-5b, CA-6, CA-7, and CA-20, CA-8, and CA-20a, CA-16, and CA-17 (11/97A)

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FECA CIRCULARS--TEXT

FECA CIRCULAR NO. 98-01 **January 27, 1998**

SUBJECT: SELECTED ECAB DECISIONS FOR JANUARY - MARCH, 1997

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

Of particular interest is the decision in Donald E. Ewals, which deals with performance of duty/compensable employment factors. This decision is included in its entirety, as well as in summary form. Additional topics addressed in the summaries are schedule awards, parent dependency, loss of wage-earning capacity determinations based on actual earnings, refusal of suitable work, use of unsigned investigative reports, and the relevance of disability determinations made by other programs to eligibility for FECA benefits.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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AUGMENTED COMPENSATION - PARENT DEPENDENCY

Josephine Bellardita, Docket No. 95-346, Issued February 26, 1997

In this case, the Board reiterated its position with respect to claiming a parent as a dependent.

Section 8110(a)(4) of the Act states, "For the purposes of this subsection, ‘dependent' means parent, while wholly dependent on and supported by the employee." In previous decisions, the Board has defined "wholly dependent" as "[having] no consequential source as means of maintenance other than the earnings of the employee." They have also stated that the dependent may have some inconsequential or slight earnings or savings, or some other slight property.

In *Joan L. Harris* (33 ECAB 1620 [1982]), $284.30 per month in Social Security benefits was not considered to be an inconsequential or slight source of income. In this case, the claimant's mother received $480.00 per month in Social Security benefits, and $69.00 and $48.00 per month in pension benefits. These are not considered to be inconsequential or slight sources of income under the Act, and the mother was therefore not a dependent under the FECA. The fact that the mother might be considered an eligible dependent by other agencies, including the Internal Revenue Service, was irrelevant.

DISABILITY DETERMINATIONS UNDER OTHER BENEFITS PROGRAMS

Elmore T. Carter, Docket No. 97-121, Issued January 9, 1997

The interesting portion of this decision concerns the relevance of disability determinations made by other benefits programs to eligibility for benefits under the Federal Employees' Compensation Act. In this case, the claimant had submitted a decision of the Social Security Administration in support of his request for reconsideration. The Board stated:

> the decision of an administrative law judge finding that an appellant is disabled under the Social Security Act for purposes of receiving social security benefits is not dispositive in this case because, as the Board has previously held, entitlement to benefits under one act does not establish entitlement to benefits under the [FECA] Act [*Daniel Deparini*, 44 ECAB 657, 1993]. In determining whether an employee is disabled under the Act, the findings of the Social Security Administration are not determinative of disability under the Act. The Social Security Act and the Act have different standards of medical proof on the question of disability. Therefore, disability under one statute does not establish disability under the other statute. Furthermore, under the Act, for a disability determination, appellant's injury or occupational disease must be shown to be causally related to an accepted injury or factors of his federal employment. Under the Social Security Act, conditions which are not employment related may be taken into consideration in rendering a disability determination.

LOSS OF WAGE-EARNING CAPACITY - ACTUAL EARNINGS

Monique L. Love, Docket No. 95-188, Issued February 28, 1997

In this case, the claimant returned to full-time work in a modified distribution clerk position after a period of total disability. The Office subsequently determined that the modified job fairly and reasonably represented the claimant's wage-earning capacity, and that she was not entitled to compensation for wage loss because her earnings in the new job exceeded the contemporaneous rate of pay for her old job. The claimant had been working in the new job for more than sixty days at the time the Office issued its decision.

The Board affirmed the Office's decision. In doing so, the Board reviewed several arguments made by the claimant, which disputed the correctness of the decision. The claimant argued that the Office did not make a reasoned determination regarding whether her earnings as a modified distribution clerk fairly and reasonably represented her wage-earning capacity because it did not adequately consider whether the position was a "sheltered" position, designed for her particular needs. The Board found that the record did not contain evidence that the position was part-time, sporadic, seasonal, or temporary, or that it was a make-shift position designed for the claimant's

needs. They noted the dissimilarity between this situation and those found in other decisions where the actual earnings did not represent the claimant's wage-earning capacity (*Michael A. Wittman*, 43 ECAB 800, and *Elizabeth E. Campbell*, 37 ECAB 224).

The claimant also argued that the Office must consider the seven criteria enumerated in section 8115(a) of the Act when determining whether actual earnings fairly and reasonably represent wage-earning capacity. The Board noted that the seven criteria were to be considered only when evaluating the appropriateness of a constructed position as a measure of wage-earning capacity.

PERFORMANCE OF DUTY - FACTORS OF EMPLOYMENT

<u>Donald E. Ewals, Docket No. 94-2604, Issued February 6, 1997</u>

In recent years, a large number of ECAB decisions which discuss the necessity of distinguishing between compensable and non-compensable employment factors have been included in the quarterly ECAB summaries. The reasons for this are many: the complicated issues involved in making such distinctions; the high ECAB remand rate on this issue; and the rising number of claims which require this type of case development. Claims examiners have become increasingly skilled in delineating between compensable and non-compensable employment factors in both statements of accepted facts and formal decisions.

This case was on appeal previously before the Board. A summary of the prior decision, Docket No. 92-1291, issued October 8, 1993, was included in FECA Circular No. 94-8, which was published on May 26, 1994. At that time, the Board remanded the case for further development of the factual evidence, preparation of a statement of accepted facts, and referral for medical evaluation. They stated that non-compensable factors of the claimant's employment included internal reorganization of the claimant's agency, proposed procedural changes, and the supervisor's non-response to the opinions of program managers, because reaction to these matters would arise out of the claimant's desire to work in a particular environment, rather than his assigned duties. They did find, however, that compensable factors could arise to the extent that the changes in the agency affected the claimant directly in the performance of his regular or specially assigned duties. They found that personnel matters involving use of sick leave, controls placed on the use of sick leave, counseling concerning leave, and requests to undergo fitness-for-duty examination are not compensable factors, without a finding of error or abuse on the part of the employer. They found that the claimant alleged that changes in stock numbers for repair parts had increased his work load, and directed the Office to develop this matter. They also found that the Office had not made findings on the claimant's allegations of verbal abuse by his supervisor.

Upon return of the case to the district office, after additional development of the factual evidence, the Office again denied the claim on the basis that the evidence of record failed to demonstrate that the claimed injury occurred in the performance of duty. The Board found that

the case was not in posture for decision, and remanded it for further development, including medical referral. Because the discussion is so lengthy, the entire decision is attached. To summarize briefly, the Board found that: (1) the Office failed to follow the Board's previous instructions; (2) the Office erred in not making a distinction between disagreement with changes in policy (non-compensable) and the effects of policy changes on assigned duties (compensable); (3) several instances of verbal abuse by his supervisor would be considered compensable factors of employment, as would his tense relationship with his supervisor; and (4) the Office had erred in stating that a finding of harassment must be made by an authority other than the Office, and that in the absence of such a finding, the Office would assume no harassment had occurred.

REFUSAL OF SUITABLE WORK - RETROACTIVE DETERMINATIONS; USE OF UNSIGNED INVESTIGATIVE REPORTS

Ricky L. Harrison, Docket No. 94-2570, Issued January 7, 1997

This claim was accepted for a lumbar strain. At the time of injury, the claimant, a Postal worker, had just transferred to a job in Des Moines, Iowa, after a reduction in force at his local office. The commute to Des Moines from his home was approximately two hours long.

The claimant's treating physician, a Board-certified orthopedic surgeon, reported that the claimant could return to a light-duty position, with restrictions, working four hours per day for the first two weeks, six hours per day the second two weeks, and perhaps eight hours per day after that. He also stated that the claimant should not commute to Des Moines, but if no alternative was available, he could work in Des Moines three days per week, four hours per day.

The claimant returned to work in Des Moines for four hours of light duty on March 19, 1993, but sought emergency room treatment later that day and did not work further. The attending physician stated that the claimant's back condition had been exacerbated by the commute on March 19.

On June 1, 1993, the attending physician reported that the claimant could return to work at a local office with restrictions, beginning with four hours per day, and increasing hours to six, and then eight per day. The Office referred the claimant to a Board-certified orthopedist for a second opinion evaluation. The second opinion examiner concluded that the claimant could return to work four hours per day, and work up to eight hours per day after three months, and that although he was resistant, he was able to commute to Des Moines.

The Office found that there was a conflict of opinion regarding whether the claimant could commute to Des Moines, and referred the claimant for evaluation by an impartial orthopedic surgeon. The impartial examiner agreed with the physical restrictions outlined by the previous physicians, and stated that he was able to commute to Des Moines.

In the meanwhile, the Office received unsigned reports from Postal inspectors which stated that the claimant had been observed driving 200 miles round trip for two days, sitting at a horse show for two hours without getting up in April, 1993, and lifting and carrying bales of hay weighing 40 to 60 pounds each on April 3, 1993. This information was provided to the impartial examiner, along with the report of an MRI scan, and he was asked whether there were objective findings of disability beginning March 20, 1993. The impartial examiner responded that the MRI findings were not consistent with the claimant's symptoms, and that he had suffered a myofascial strain from which he had now recovered. He stated that the claimant could return to light-duty work full-time for one month, then resume regular work. He noted that his recommendations had changed in light of the additional information which had been sent to him (concerning driving long distances, lifting bales of hay, etc.).

The Office issued a proposed termination of compensation, based on the impartial physician's report, stating that the claimant had recovered from his employment injury. The claimant's representative submitted affidavits from the claimant's spouse and daughter refuting the report of the Postal inspectors.

The Office advised the claimant that the light duty position which had been offered to him on March 9, 1993 (and which he worked on March 19 only, but not thereafter) was found to be suitable, that the job was still available, and that failure to accept a suitable job without good reason was basis for termination of compensation. He was given 30 days to advise the Office if he had good reasons for not accepting the limited-duty offer.

The claimant's representative responded that the claimant wanted to accept work made available to him within his physician's restrictions, and submitted a report from the attending physician which reiterated the previous restrictions, and stated that the claimant should not commute a long distance, but rather work in the local area.

The Office issued a compensation order denying benefits, because there was no causal relationship between the injury and the claimed disability, and because since no recurrence of disability was established as of March 20, 1993, the claimant had abandoned suitable employment.

The Board found that the Office did not meet its burden of proof to terminate benefits. They found that the initial report of the impartial specialist represented the weight of the medical evidence. In that report, the specialist found that partial disability continued, but that the claimant was able to return to work as of June, 1993. The specialist later stated that the claimant's work-related condition had resolved, based upon information from the Postal inspector reports. However, since these reports were not signed, they could not be presumed to be factual, and a medical opinion based on them would be of diminished probative value. The Office did not establish by the weight of the medical evidence that disability had ceased, and had not therefore met its burden of proof.

In addition, the Board found that the Office improperly determined that the claimant had abandoned suitable work. First, the record did not contain a description of the light-duty job, and so the Board was unable to determine why the Office found the job suitable, given the claimant's work restrictions. Secondly, the Office may not make retroactive determinations of suitability. The Office did not find that the job was suitable until after the claimant had returned to work, and then stopped working. By making a retroactive suitability determination, the Office deprived the claimant of the opportunity to return timely to the job.

SCHEDULE AWARD - APPLICATION OF PROGRAM MEMORANDUM NO. 88

Edward Szela, Docket No. 95-881, Issued February 19, 1997

The claimant in this case was awarded 25 percent permanent impairment of his right middle finger, based upon partial amputation of the distal phalanx. The physician who provided the information used to calculate the award did not provide a percentage of impairment, but did state that less than 50 percent of the distal phalanx had been amputated, and gave range of motion measurements for the joints of the finger. This report was reviewed by an Office medical advisor, who cited FECA Program Memorandum No. 88, stated that the amputation as described equals a 25 percent loss of function, and further stated that the loss of range of motion of the digit was "included as expected residuals" and was thus not supposed to be calculated separately.

The Board set aside the Office's decision. They noted that FECA Program Memorandum No. 88 provides:

> If there is loss of less than one-half of the first phalanx of a digit with some loss of bone, or amputation of bony tuft, the award for this loss shall be one-half of the amount payable for the loss of the first phalanx or for 25 percent of the digit.

They further noted that the Memorandum also states:

> If the injury has caused disability in addition to the amputation, such as impairment of flexion or extension, swelling, gross deformity and/or change in sensation, such additional disability must be taken into consideration in the overall award determination.

Because the Office medical advisor incorrectly disregarded the reported loss of motion, the award was incorrect, and the case was remanded for recalculation of the degree of impairment.

SCHEDULE AWARD FOR HEARING LOSS - REVISED AWARD VS NEW OR ADDITIONAL INJURY

Stacey L. Walker, Docket No. 95-873, Issued February 21, 1997

The Office made an award in this case for two percent binaural hearing loss, based upon the September 15, 1993 examination of an otolaryngologist who was Board-certified in plastic surgery, but not in otolaryngology.

The claimant requested reconsideration, and submitted an audiogram and report from a Board-certified otolaryngologist dated August 9, 1994. The Office denied modification of the previous decision, stating that the new report failed to include a rationalized opinion that the claimant had hearing loss greater than two percent.

The claimant again requested reconsideration, and stated that the audiogram could be verified. The Office again denied modification on the basis that the evidence submitted was already contained in the file and was not sufficient to warrant review.

The Board remanded the case for further development. They noted that where there are different audiograms from different specialists within a two-year period, all such audiograms should be evaluated to determine the percentage loss of hearing. They also noted that according to the Federal (FECA) Procedure Manual, Chapter 2-0808.7b(3), when a schedule award is made before the exposure terminates (as was the situation in this case), no additional awards are to be paid for periods of less than one year from the beginning date of the last award or the date of last exposure, whichever comes first. In hearing loss cases, a claim for an additional schedule award is based upon additional exposure, and constitutes a new claim, and should be treated as such. If a claimant asks for review of a hearing loss schedule award, he or she must be asked whether the request is for review of the award or for additional compensation due to additional exposure. If the request is based on additional exposure, a new claim should be filed no sooner than one year from the beginning date of the previous award, or the date of last exposure, whichever comes first.

In this case, the Office sent the claimant to a physician who was not Board-certified in the appropriate specialty. The office did not consider another audiogram which was submitted less than one year after the first one. In addition, the Office did not ask the claimant whether he was seeking reconsideration of the original award or an additional award. The Office's denial of modification based upon the lack of rationale was inappropriate, as the Office had already accepted the condition as work-related.

FECA CIRCULAR NO. 98-02 **October 24, 1997**

SUBJECT: Revised Forms CA-1, CA-2, CA-5, CA-5b, CA-6, CA-7, and CA-20, CA-8, and CA-20a, CA-16, and CA-17

Attached please find copies of the above referenced forms which were recently revised.

Please discard all copies of the former versions of the forms. As all of these revisions have legal implications, use of the outdated forms is prohibited.

Agencies that produce these forms should discard their previous versions of these forms.

District Offices may obtain the forms from the Department of Labor warehouse through regional supply channels. Federal agencies may purchase the forms from the Superintendent of Documents, Government Printing Office (GPO), Washington, D.C. 20402. The current stock number and price may be obtained by calling the GPO on (202)783-3238. Agencies may also reproduce these forms provided they are exact duplicates of the forms, including color, typeface and spacing.

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

FECA CIRCULAR NO. 98-03 **October 22, 1997**

SUBJECT: Dual Benefits - FERS

Reference is made to FECA Bulletin 97-9, where the procedures for computing FERS Dual Benefits are outlined. In action item 3, the bulletin states that Bill Hilton is the individual at SSA who will perform the necessary computations for OWCP. A new individual at SSA is now performing this task. Effective immediately Taz Callanan (please note spelling) at FAX number (410) 966-1042 is performing the computations in FERS Dual Benefits cases. His phone number is (410) 965-9293.

Please change the name and number in Bulletin 97-9, in both places where Bill Hilton's name and number appear (Action Item 3, paragraphs 2 and 6).

Any FERS SSA Dual Benefits Forms which were sent to Bill Hilton will be computed by Taz Callanan and returned to you.

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FECA CIRCULAR NO. 98-04 October 22, 1997

SUBJECT: Code Changes for the Departments of Agriculture, Defense, Navy, Transportation, Treasury, and Veterans Affairs, and the General Services Administration, National Aeronautics and Space Administration, and Other Establishments, Case Management Users' Manual, Appendix 4-7

The Case Management User's Manual is being updated and revised to reflect multiple changes, including the addition of several new codes. For the Department of Agriculture, multiple agencies have been added, renamed, and removed from the Users' Manual as noted below. For the Department of Defense, the Defense Mapping Agency has been re-named the National Imagery and Mapping Agency (NIMA); facilities in that agency have been re-named accordingly, and 2 new codes have been added to reflect additional NIMA facilities. For the Department of the Navy, the Naval Investigative Service has been re-named the Naval Criminal Investigative Service. For the Department of Transportation, three new chargeback codes have been added to reflect injuries sustained by employees of the Transportation Administrative

Service Center (code 2510), the Bureau of Transportation Statistics (code 2512), and the Surface Transportation Board (code 2514). For the Department of the Treasury, a major reorganization within the Internal Revenue Service (IRS) has reduced the number of IRS regions from 7 to 4; three regions have been removed from the User's Manual, two have been re-named, and state jurisdictions have all been changed. For the Department of Veterans Affairs, 6 new codes have been added to reflect injuries reported by employees of Consolidated Mail Order Pharmacies (CMOP), and codes have also been added for employees of Tahoma National Cemetery (code 4494), the VA Regional Office in Austin (code 4727), and the Payroll Service Center in Topeka, Kansas (code 4521). For the General Services Administration, 77 new codes have been added to reflect a change in coding structure from functional to regional. For the National Aeronautics and Space Administration, new codes have been added to reflect injuries reported by employees of the Stennis Space Center (code 1789, replacing an unused code) and the Office of Inspector General (code 1792). Finally, in the Other Establishments category, chargeback code 1488 has been added to reflect a separate code for employees of the U.S. Capitol Police, and chargeback code 1489 has been added to reflect a separate code for employees of the Utah Reclamation Migration and Conservation Commission.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Trans-action type	Code	Dept.	Agency
Add	8220	Agricltre	Office of Budget & Program Analysis
" "	8221	" "	Office of Congressional & Intergovernmental Rel
" "	8223	" "	Office of the Chief Economist
" "	8224	" "	National Appeals Division
" "	8414	" "	ARS, Beltsville Area
" "	8415	" "	ARS, Pacific/Northern Plains Areas
" "	8416	" "	ARS, MidWest/North Atlantic Areas
" "	8417	" "	ARS, Southern Plains Areas
" "	8418	" "	ARS, MidSouth Area
" "	8505	" "	FSA, State Offices

“ “	8506	“ “	FSA, Kansas City Field Office
“ “	8507	“ “	FSA, Aeriel Photography Field Office
“ “	8511	“ “	RMA, Deputy Admin for R & D
“ “	8512	“ “	RMA, Kansas City Compliance Field Office
“ “	8513	“ “	RMA, Regional Service Offices
Add	2510	DOT	Transportation Administrative Service Center
“ “	2512	“ “	Bureau of Transportation Statistics
“ “	2514	“ “	Surface Transportation Board
Add	3058	Defense	NIMA Arnold
“ “	3070	“ “	NIMA Navy Yard
Add	4035	VA	W Los Angeles Consol Mail Order Pharmacy (CMOP)
“ “	4082	“”	Hines CMOP
“ “	4110	“”	Leavenworth CMOP
“ “	4139	“”	Bedford CMOP
“ “	4296	“”	Murfreesboro CMOP
“ “	4305	“”	Dallas CMOP
“ “	4494	“”	Tahoma National Cemetery
“ “	4521	“”	VA HR/Payroll Service Center, Topeka, Kansas
“ “	4727	“”	VA Regional Office Austin
Add	1618	GSA	NATIONAL CAPITAL REGION, Admin and Staff Ofcs
“ “	1619	“ “	NATIONAL CAPITAL REGION, Public Buildings Svce
“ “	1621	“ “	NATIONAL CAPITAL REGION, Ofc of Property Mgmt
“ “	1622	“ “	NATIONAL CAPITAL REGION, Fed Supply Svce
“ “	1626	“ “	NATIONAL CAPITAL REGION, Ofc of Inspector Gnrl
“ “	1627	“ “	NATIONAL CAPITAL REGION, Fed Telecomm Svce
“ “	1628	“ “	NATIONAL CAPITAL REGION, Other
“ “	1630	“ “	ADMIN & STAFF OFFICES Northwest/Arctic Region
“ “	1631	“ “	ADMIN & STAFF OFFICES New England Region
“ “	1632	“ “	ADMIN & STAFF OFFICES Northeast & Carribean Rgn
“ “	1633	“ “	ADMIN & STAFF OFFICES Mid-Atlantic Region
“ “	1634	“ “	ADMIN & STAFF OFFICES Southeast Sunbelt Region
“ “	1635	“ “	ADMIN & STAFF OFFICES Great Lakes Region
“ “	1636	“ “	ADMIN & STAFF OFFICES Heartland Region
“ “	1637	“ “	ADMIN & STAFF OFFICES Greater Southwest Region
“ “	1638	“ “	ADMIN & STAFF OFFICES Rocky Mountain Region
“ “	1639	“ “	ADMIN & STAFF OFFICES Pacific Rim Region

Trans-action type	Code	Dept.	Agency
Add	1640	GSA	PUBLIC BUILDINGS SVCE Northwest/Arctic Region
" "	1641	" "	PUBLIC BUILDINGS SVCE New England Region
" "	1642	" "	PUBLIC BUILDINGS SVCE Northeast & Carribean Rgn
" "	1643	" "	PUBLIC BUILDINGS SVCE Mid-Atlantic Region
" "	1644	" "	PUBLIC BUILDINGS SVCE Southeast Sunbelt Region
" "	1645	" "	PUBLIC BUILDINGS SVCE Great Lakes Region
" "	1646	" "	PUBLIC BUILDINGS SVCE Heartland Region
" "	1647	" "	PUBLIC BUILDINGS SVCE Greater Southwest Region
" "	1648	" "	PUBLIC BUILDINGS SVCE Rocky Mountain Region
" "	1649	" "	PUBLIC BUILDINGS SVCE Pacific Rim Region
" "	1650	" "	OFC OF PROPERTY MGMT Northwest/Arctic Region
" "	1651	" "	OFC OF PROPERTY MGMT New England Region
" "	1652	" "	OFC OF PROPERTY MGMT Northeast & Carribean Rgn
" "	1653	" "	OFC OF PROPERTY MGMT Mid-Atlantic Region
" "	1654	" "	OFC OF PROPERTY MGMT Southeast Sunbelt Region
" "	1655	" "	OFC OF PROPERTY MGMT Great Lakes Region
" "	1656	" "	OFC OF PROPERTY MGMT Heartland Region
" "	1657	" "	OFC OF PROPERTY MGMT Greater Southwest Region
" "	1658	" "	OFC OF PROPERTY MGMT Rocky Mountain Region
" "	1659	" "	OFC OF PROPERTY MGMT Pacific Rim Region
" "	1660	" "	FEDERAL SUPPLY SVCE Northwest/Arctic Region
" "	1661	" "	FEDERAL SUPPLY SVCE New England Region
" "	1662	" "	FEDERAL SUPPLY SVCE Northeast & Carribean Rgn
" "	1663	" "	FEDERAL SUPPLY SVCE Mid-Atlantic Region
" "	1664	" "	FEDERAL SUPPLY SVCE Southeast Sunbelt Region
" "	1665	" "	FEDERAL SUPPLY SVCE Great Lakes Region
" "	1666	" "	FEDERAL SUPPLY SVCE Heartland Region
" "	1667	" "	FEDERAL SUPPLY SVCE Greater Southwest Region
" "	1668	" "	FEDERAL SUPPLY SVCE Rocky Mountain Region
" "	1669	" "	FEDERAL SUPPLY SVCE Pacific Rim Region
" "	1670	" "	OFC OF INSPECTOR GNRL Northwest/Arctic Region
" "	1671	" "	OFC OF INSPECTOR GNRL New England Region
" "	1672	" "	OFC OF INSPECTOR GNRL Northeast & Carribean Rgn
" "	1673	" "	OFC OF INSPECTOR GNRL Mid-Atlantic Region
" "	1674	" "	OFC OF INSPECTOR GNRL Southeast Sunbelt Region
" "	1675	" "	OFC OF INSPECTOR GNRL Great Lakes Region
" "	1676	" "	OFC OF INSPECTOR GNRL SVCE Heartland Region
" "	1677	" "	OFC OF INSPECTOR GNRL Greater Southwest Region

“ “ 1678 “ “ OFC OF INSPECTOR GNRL Rocky Mountain Region
“ “ 1679 “ “ OFC OF INSPECTOR GNRL Pacific Rim Region
“ “ 1680 “ “ FED TELECOMMCTNS SVCE Northwest/Arctic Region
“ “ 1681 “ “ FED TELECOMMCTNS SVCE New England Region
“ “ 1682 “ “ FED TELECOMMCTNS SVCE Northeast & Carribean Rgn
“ “ 1683 “ “ FED TELECOMMCTNS SVCE Mid-Atlantic Region
“ “ 1684 “ “ FED TELECOMMCTNS SVCE Southeast Sunbelt Region
“ “ 1685 “ “ FED TELECOMMCTNS SVCE Great Lakes Region
“ “ 1686 “ “ FED TELECOMMCTNS SVCE Heartland Region
“ “ 1687 “ “ FED TELECOMMCTNS SVCE Greater Southwest Region
“ “ 1688 “ “ FED TELECOMMCTNS SVCE Rocky Mountain Region
“ “ 1689 “ “ FED TELECOMMCTNS SVCE Pacific Rim Region

Trans-action type	Code	Dept.	Agency
Add	1690	GSA	NOT OTHRWISE CLASSIFD Northwest/Arctic Region
“ “	1691	“ “	NOT OTHRWISE CLASSIFD New England Region
“ “	1692	“ “	NOT OTHRWISE CLASSIFD Northeast & Carribean Rgn
“ “	1693	“ “	NOT OTHRWISE CLASSIFD Mid-Atlantic Region
“ “	1694	“ “	NOT OTHRWISE CLASSIFD Southeast Sunbelt Region
“ “	1695	“ “	NOT OTHRWISE CLASSIFD Great Lakes Region
“ “	1696	“ “	NOT OTHRWISE CLASSIFD Heartland Region
“ “	1697	“ “	NOT OTHRWISE CLASSIFD Greater Southwest Region
“ “	1698	“ “	NOT OTHRWISE CLASSIFD Rocky Mountain Region
“ “	1699	“ “	NOT OTHRWISE CLASSIFD Pacific Rim Region
Add	1792	NASA	Office of Inspector General
Add	1488	Other Est	U.S. Capitol Police
“ “	1489	“ “	Utah Reclamation Migration & Conservation Comm
Change	8201	Agricltre	from: Office of Finance and Management to: Office of the Chief Financial Officer
“ “	8202	“ “	from: Office of Personnel to: Office of Human Resources Management

“ “ 8204 “ “ from: Office of Public Affairs
to: Office of Communications

“ “ 8205 “ “ from: Office of Advocacy and Enterprise
to: Office of Civil Rights

“ “ 8208 “ “ from: Office of Information Resrcs Management
to: Office of the Chief Information Officer

“ “ 8216 “ “ from: Office of Safety & Health Management
to: National Finance Center

“ “ 8502 “ “ from: Federal Crop Insurance Corporation
to: Risk Management Agency (RMA)

“ “ 8603 “ “ from: Rural Development Administration
to: Rural Business-Cooperative Service

“ “ 8801 “ “ from: Other Workers, Non-Federal employees
to: Food & Nutrition Program employees

Trans-action type	Code	Dept.	Agency
Change	3042	Defense	from: Defense Mapping Agency headquarters to: Natl Imagery and Mapping Agency headqrtrs
“ “	3043	“ “	from: DMA Aerospace Center to: NIMA St. Louis
“ “	3044	“ “	from: DMA Hydrographic/Topographic Center to: NIMA Bethesda
“ “	3045	“ “	from: DMA Combat Support Center to: NIMA Philadelphia
“ “	3046	“ “	from: DMA Reston Center to: NIMA Reston

“ “ 3047 “ “ from: DMA Systems Center
to: NIMA Westfields

“ “ 3048 “ “ from: Defense Mapping School
to: NIMA Ft. Belvoir College

“ “ 3012 “ “ from: Telecommunications Service Center
to: NIMA North Annex

Change 617x Navy from: Naval Investigative Service
to: Naval Criminal Investigative Service

Change 2151 Treasury from: IRS Southeast Region (Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee)
to: IRS Southeast Region (Alabama, Arkansas, Delaware, Florida, Georgia, Indiana, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia)

“ “ 2155 “ “ from: IRS Southwest Region (Arizona, Colorado, Kansas, New Mexico, Oklahoma, Texas, Utah, Wyoming)
to: IRS Midstates Region (Arkansas, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, Wisconsin)

“ “ 2159 “ “ from: IRS Western Region (Alaska, California, Hawaii, Idaho, Nevada, Oregon, Washington)
to: IRS Western Region (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming)

Transaction type	Code	Dept.	Agency
Change	2160	Treasury	from: IRS North Atlantic Region (Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont)

		to: IRS Northeast Region (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont)	
Change	1789	NASA	from: NASA Pasadena Office to: Stennis Space Center, Bay St. Louis, Miss
Delete	8409	Agricltre	Cooperative State Research, Education & Extension Service
" "	8501	" "	Commodity Credit Corporation
" "	8103	" "	Ofc of Intl Cooperation and Development
" "	8608	" "	Agricultural Cooperative Service
" "	8218	" "	Office of Transportation
Delete	2153	Treasury	IRS Midwest Region
" "	2154	" "	IRS Central Region
" "	2158	" "	IRS Mid-Atlantic Region

Distribution: List No. 5 - Folioviews Groups C and D
(All Supervisors, Index and Files Personnel, Systems Managers and Technical Assistants)
Note: Immediate distribution to chargeback coding personnel is essential.

FECA CIRCULAR NO. 98-05 **November 5, 1997**

SUBJECT: Dual Benefits - FERS COLA

Effective December 1, 1997, Social Security Benefits will increase by 2.1%. That requires the amount of the FERS Dual Benefits Deduction to be increased by the same amount.

This adjustment will be made from the National Office and will affect all cases that are correctly entered into the revised ACPS Program. The adjustment will be made effective with the periodic roll cycle beginning December 7, 1997. No adjustment will be made for the period December 1, 1997 through December 6, 1997.

If there are any cases currently being adjusted for FERS Dual Benefits that have not been entered correctly, please ensure that the correction is made by December 1, 1997.

The National Office will provide a notice to each record effected with a copy for the case file.

SSA COLA's are as follows:

Effective December 1, 1997	2.1%
Effective December 1, 1996	2.9%
Effective December 1, 1995	2.6%
Effective December 1, 1994	2.8%

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 98-06 **November 13, 1997**

SUBJECT: Selected ECAB Decisions for October - December, 1996

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

Summaries on a variety of topics are included.

No summaries are being published for January through March, 1996.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

(Claims Examiners, All Supervisors, District Medical Advisers, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)
COMPENSATION FOR SECOND OPINION EXAMINATIONS CONDUCTED ON NON-WORK DAY

Antonio Mestres, Docket No. 94-2247, Issued October 21, 1996

In this case, the claimant had returned to work six hours per day and was receiving compensation for the remaining two hours per day. The Office referred him for evaluation by a second opinion orthopedic specialist. The orthopedist examined the claimant on two different dates, both of which were not scheduled work days. The claimant submitted a claim for eleven hours of compensation for the time spent being evaluated. The Office denied the claim for eleven hours.

The Board affirmed the Office's decision. The Board stated that Section 8103 provides for payment of loss of wages incurred while obtaining medical services. In the case at hand, however, the claimant sustained no loss of wages because he was not scheduled to work on the days he was examined.

The claimant attempted to argue that his union contract with the employer stated that he could not be required by the employer to attend any medical evaluation scheduled during non-work hours. The medical examination in this instance was not scheduled by the employer, but rather by the Office, and the union agreement was neither applicable nor binding.

FACT OF INJURY - NEUTRAL RISK

Doyle W. Ricketts, Docket No. 95-435, Issued November 6, 1996

In this decision, the Board found that exposure to a "neutral risk" is compensable.

The claimant, a rural mail carrier, claimed that on June 23, 1993, he sustained a traumatic injury to his left foot. On the morning of June 23, he felt a stinging sensation in his left heel. He no longer felt it after he moved his foot around in his shoe. Later that evening, he noticed soreness and a lump in the instep/heel area of his left foot. Although he had not seen a spider at the time, he believed that he had been bitten by a spider, based on what he had read about spider bites, and the fact that he had seen spiders in the mailboxes that he served. The claimant's description of the incident was consistent through several accounts to OWCP and two physicians.

He tried home remedies without success. He first sought medical treatment on August 23. The treating physician submitted a medical report which supported symptoms and a diagnosis consistent with a spider bite 2 months prior.

The Office denied the claim on the grounds that the claimant did not establish fact of injury. In response to one request for reconsideration, modification was denied. In response to another, the Office denied review. The Board found that the claimant met his burden of proof to establish that he sustained an injury in the performance of duty, stating "That the precise mechanism of the injury or the exact identity of the offending creature proved elusive is not fatal to appellant's claim." The Board provides the following discussion of Larson.

Larson has identified three types of risks: 1) risks distinctly associated with the employment - these are universally compensable; 2) risks personal to the claimant - these are universally noncompensable; and 3) "neutral" risks, i.e. risks having no particular employment or personal character.

Harms from this third risk are the subject of controversy in modern compensation law, but there is increased acceptance for finding an injury arose in the performance of duty when a condition of employment put the claimant in a position to be injured by the neutral risk. The Board has applied the positional risk doctrine, and has held that an injury arising in the course of employment from a neutral risk is compensable ... In the present case, the harm experienced by appellant appeared to have been distinctly associated with his employment in that he noticed a stinging sensation in the area of the claimed injury while at work, experienced apparent after effects shortly thereafter and was later diagnosed as having a spider bite.

FACT OF INJURY - PAIN REPORTED BY PHYSICIAN AS A DIAGNOSIS

Mable A. Stewart, Docket No. 95-22, Issued November 19, 1996

The principle enunciated in this case was that a physician's finding of pain can be sufficient to constitute medical evidence in support of "fact of injury".

The claimant reported an injury of September 29, 1992, when she caught her foot under a chair and fell, striking her head against a wall, and her arm and buttocks on the floor. A witness confirmed the fall. It was accepted that the incident occurred as alleged.

Since fact of injury consists of two components, the next question was whether the claimant sustained an injury as a result of the accepted incident. The district office had denied the claim on the basis that fact of injury was not established. Medical evidence submitted included diagnoses of "musculoskeletal neck and arm pain", and "mild post-concussive syndrome". The Board found that the second diagnosis clearly constituted an injury-related diagnosis, establishing fact of injury.

The Board also noted that although the Procedure Manual at PM-2-803.3(d) states that "findings of pain or discomfort alone do not satisfy the medical aspect of the fact of injury determination," where "musculoskeletal pain" is presented by a physician as a final and definite diagnosis resulting from a clear traumatic incident, rather then merely mentioned as an employee complaint or as findings upon examination, such a diagnosis is sufficient to establish an injury.

The Office's decision was reversed.

PERFORMANCE OF DUTY - SHIFT CHANGES FOR DISCIPLINARY REASONS

Gabriel Imondi, Docket No. 95-238, Issued November 5, 1996

The point in this decision worth noting is that the Board found that while a change in work-shift is generally considered a factor of employment, if the shift change is for disciplinary reasons, it is considered an administrative action covered by McEuen.

The claimant filed a claim for an emotional condition which he attributed to his employment as a medical clerk. He claimed, among other things, that changing his shift from the night shift to working days and weekends without adequate time to adjust his schedule interfered with his sleep patterns. The lack of sleep, he claimed, was stressful and caused him to be irritable.

A board-certified psychiatrist submitted reports stating that the change in the claimant's shift from the night shift to the day shift caused his emotional condition, resulting in depression, confusion and inability to concentrate.

The agency stated that the claimant was changed to the day shift to remove him from conflicts and personal relationships with coworkers on the night shift; to allow for closer supervision, restore productivity, maintain discipline and restore morale.

The Board found that the change in shift was an administrative action taken by the agency to reduce conflict between the claimant and coworkers, and was in essence a disciplinary action. The administrative action in changing the claimant's shift, in the context of enforcing discipline and restoring order to the agency, is covered by McEuen and would be considered outside of the performance of duty unless it were established that the action was abusive or in error.

While the claimant did cite some potentially covered factors of employment, he did not provide medical evidence attributing a medical condition to any of the claimed factors considered to be in the performance of duty. The Board, therefore affirmed the Office's decision.

RECONSIDERATIONS - MERIT REVIEW

Andrew Guzman, Docket No. 94-2611, Issued November 15, 1996

In this case, the Board reminds us that where the claimant does not receive a decision on a request for reconsideration within 90 days of receipt of the request, the Office must perform a merit review of the file.

By decision of April 30, 1992, the Office denied the claim for hearing loss as non-ratable. By decision of March 24, 1993, a Hearing Representative affirmed the decision.

On April 19, 1993, the claimant's representative requested reconsideration arguing that the audiogram utilized by the Office was of questionable accuracy. By decision of March 21, 1994, the Office found that, as the claimant neither raised substantial legal questions nor included new and relevant evidence, the request was insufficient to warrant review of the prior decision.

The Board, referencing PM-2-1602.7, found that because the Office did not issue a decision on the request for review until eleven months after the decision, the claimant was precluded from seeking a further merit review by the Office or a Board review. The case was remanded for a de novo decision on the merits of the claim.

SUSPENSION OF BENEFITS UNDER SECTION 8123(d)

Gloria D. Livingston, Docket No. 94-2573, Issued October 22, 1996

The claimant sustained an injury in 1986 which was accepted for acute lumbosacral sprain and aggravation of upper back and shoulder girdle fibrosis. A physician who was Board-certified in preventative medicine examined the claimant and found that her subjective complaints of paid vastly outweighed the objective findings, and recommended referral for a behavioral pain management program and a functional capacity assessment. On July 16, 1993, the Office exercised its discretion under Section 8123(a) and referred the claimant for functional capacity evaluation. The claimant was advised that refusal or obstruction of the examination would result in suspension of her compensation under Section 8123(d). The claimant reported for the examination, but did not cooperate. The testing was to have lasted for three hours, but the claimant repeatedly refused to participate in testing, and stopped prior to maximum effort. The rehabilitation physical therapist noted that the claimant was observed with a greater range of motion than she would allow during testing, and stated that her overall behavior was inconsistent.

The claimant was advised again of the provision of Section 8123(d), and was asked to provide an explanation as to why she obstructed the evaluation as well as medical evidence to support her inability to undergo the testing. The claimant responded that she had been informed that the testing would last three hours, and that after three hours and forty-five minutes she left the testing due to pain. She did not submit any further medical evidence.

The Office suspended her compensation for refusal to cooperate with a medical evaluation, in accordance with Section 8123(d).

The Board affirmed the Office's decision, finding that the claimant did not offer sufficient reasons for her refusal to cooperate with the functional capacity evaluation, and did not provide any medical evidence to support an inability to participate in the evaluation. They stated that the claimant's contention that she did not refuse to cooperate with testing was refuted by the report of the rehabilitation physical therapist.

It is important to make a distinction between a functional capacity evaluation (FCE) which is a medical service recommended by a physician, and an FCE which is part of an Occupational Rehabilitation Program (ORP). In this decision, the FCE was part of a medical evaluation, and the Office properly applied the sanctions found in Section 8123(d). If in the more usual circumstance the FCE is part of an ORP, the penalty for failure to cooperate would be the appropriate rehabilitation sanctions, rather than suspension under Section 8123(d).

FECA CIRCULAR NO. 98-07 **January 7, 1998**

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

The interest rate to be assessed for the prompt payment bills is
6 1/4 percent for the period January 1, 1998 through June 30, 1998.

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

The rate for assessing interest charges on debts due the Government has not changed. The rate of 5 percent continues to be in effect through December 31, 1998.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%

7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

ATTACHMENT TO FECA CIRCULAR NO. 98-07
DMS INTEREST RATES

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 - 12/31/98	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%

Prior to 1/1/84	not applicable

FECA CIRCULAR NO. 98-08 **January 21, 1998**

SUBJECT: Revised Forms - CA-16 and CA-17

Reference is made to FECA Circular 98-2, which advised of several forms revisions, and had copies of the revised forms attached.

Revised Form CA-17 was inadvertently omitted from the Circular, and is attached hereto.

Also, the CA-16 attached to Circular 98-2 was not the current version. The revised CA-16 is attached to this circular. Please discard the CA-16 attached to Circular 98-2.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 98-09 **July 1, 1998**

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

The interest rate to be assessed for the prompt payment bills is 6.0 percent for the period July 1, 1998 through December 31, 1998.

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

The rate for assessing interest charges on debts due the Government has not changed. The rate

of 5 percent continues to be in effect through December 31, 1998.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachments

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

PROMPT PAYMENT INTEREST RATES

7/1/98 - 12/31/98	6.0%
1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%

1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

ATTACHMENT TO FECA CIRCULAR NO. 98-09

DMS INTEREST RATES

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

ATTACHMENT TO FECA CIRCULAR NO. 98-09

FECA CIRCULAR NO. 98-10 **July 30, 1998**

SUBJECT: Pay Rates: Inclusion of Extra Pay Authorized Under the FLSA

Recently, some questions have arisen regarding the inclusion of extra pay authorized under the FLSA.

The Federal (FECA) Procedure Manual outlines the pay elements that are included in the pay rate for compensation purposes in Chapter 2-900, Paragraph 7. Item 21 of that paragraph includes

> extra pay authorized under the Fair Labor Standards Act (FLSA), 29 U.S.C. 207(k), for firefighters, emergency medical technicians, and other employees who earn and use leave on the basis of their entire tour of duty, and who are required to work more than 106 hours per pay period

in the elements included in the pay rate for compensation purposes.

The elements included in the compensation pay rate are no different for Leave Buy Back than for computing compensation for Leave Without Pay.

When questions arise regarding the pay elements to either include or exclude from the pay rate for compensation purposes, PM 2-900 is the appropriate reference.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 98-11 **September 25, 1998**

SUBJECT: Bill Payment/BPS - Procedure Code Modifiers

Recently, the use of procedure modifiers has been emphasized in the keying and resolution of medical bills. This Circular provides information regarding the nature and types of modifiers considered valid in the FECS system. Additionally, the steps to be taken when resolving bills suspended because of invalid modifiers are described.

A. What are modifiers?

In medical bill processing, modifiers are extra characters attached to procedure codes. These extra characters indicate that the service performed has been changed in some way, but not sufficiently to warrant the use of another procedure code.

There are many modifiers. The AMA Physicians' Current Procedural Terminology (CPT), the Health Care Financing Administration (HCFA) HCPCS coding scheme, and several states' programs have their own unique modifiers:

1. CPT modifiers are always numeric. While they can be either two (2) or five (5) digits long, the shorter form is almost universally used. At present, the CPT contains 30 valid modifiers and a list with definitions is found in Appendix A of the 1998 edition. All these modifiers are considered as valid by the DFEC Medical Bill Processing System (MBPS).

2. HCPCS modifiers are two alpha characters appended at the end of the code. Only some of the HCPCS codes are recognized as valid by the DFEC MPBS. These are:

AA	AV
AJ	AW
AK	AY
AL	QX
AN	QZ
AS	TO
AU	SG
AH	

The definition of these codes is found in the OWCP Medical Fee Schedule Modifier Level Tables - Table A.

3. Modifiers developed by individual state programs may be composed of alpha and/or numeric characters and may vary in length. Sometimes they are difficult to distinguish from the HCPCS modifiers. One non-standard modifier that is considered valid by the DFEC system is -A for anesthesia services.

B. What are modifiers used for?

1. Modifiers indicate the character of the service performed. For example, when the CPT modifier -26 is present, it means that only the professional component of the service is being billed. Modifier - AA after a surgical code means that the service performed was the anesthesia for the procedure. Modifier -80 indicates an assistant surgeon's service.

2. Modifiers are used to express a change in the level or intensity of the service. An example of this type is modifier - 51, which indicates that the procedure is one of a number of procedures performed at the same time.

3. Modifiers also indicate who performed the service. The HCPCS modifiers used by OWCP, with the exception of TC and SG, indicate that a particular non-physician provider performed the services.

4. Not all modifiers are valid for all codes. For each procedure code for which modifiers are applicable, there is a 'modifier level". The "modifier level" refers to a list or table of modifiers that are valid for the procedure code (see D below).

C. Why are modifiers important?

Modifiers define the maximum allowable amount for the service and the correct payment for the service. For example, when modifier -81 is present, the allowable amount is only 20% of the full fee for the surgical procedure. Conversely, when modifier -22 is present, the allowable amount is 150` of the full fee.

Modifiers also define the procedure as a separate, distinct service and not a duplicate of another procedure. If a radiologist bills procedure code 71010-26 and the outpatient department of a hospital bills 71010-TC, and both are input without modifiers, the MBPS will see them as duplicates (if the EIN number of the providers is the same). Only the modifiers will identify these as separate procedures.

Therefore, modifiers are important in determining the level of payment for a service and whether the service is a duplicate or a distinct service. The appropriate use of modifiers prevents unnecessary bill suspensions and incorrect payments.

D. How to use the OWCP Medical Fee Schedule Modifier Level Tables.

1. Identify the procedure code in the OWCP Fee Schedule, then determine the Modifier Level accompanying the code. For example, procedure code 29875 has a Modifier Level of 22.

2. In the OWCP Medical Fee Schedule Modifier Level Tables, identify Table 22. Surgery, Full Service; Assistant/Two Surgeons, Bilaterality, Multiple Procedures Pro-Rated. The modifiers present in that table are the only modifiers considered valid for procedure code 29875. The level of payment is indicated after each modifier. For example, 29875-51 will be paid at 50% of the full procedure.

3. Modifiers -26 and -TC are primarily used for radiology services, clinical laboratory tests, and other clinical tests such as nerve conduction studies and EKGs. They are treated somewhat differently than other modifiers. In addition to appearing in some of the modifier level tables in the appendices, these modifiers can also be present in the fee schedule under the heading of "Modifier". For example, procedure code 72158 appears three times in the list: without modifiers (full service) but with reference to Modifier Level Table 50, with modifier -26 (professional service), and with modifier -TC (technical service). For keying purposes, the modifiers must be keyed whenever they are present on a bill.

4. Please note that a procedure may have more than one modifier. In that case, modifier -99 should be used.

E. How to resolve bills containing invalid modifiers.

When a procedure code is keyed with an invalid modifier, the bill input program will respond with an error message, "INVALID PROCEDURE CODE, MODIFIER CODE COMBINATION. CONTINUE? [Y/N]" The keyer should check the keyed procedure code and modifier on the screen against those present on the bill. If keyed accurately, he or she should answer "YES" to the question and proceed with keying. If a keying error was made, the error should be corrected.

If an invalid modifier is present, Error Code 318 will be assigned when the bill edits are run. To resolve the error, follow these steps:

1. Check that the modifier was keyed accurately. If there was a typographical error, correct it and recycle the bill.

2. If the modifier was keyed accurately, determine whether the modifier is a valid CPT modifier or one of the HCPCS modifiers applicable to DFEC bills. If the modifier is not in the CPT book, OWCP Fee Schedule Modifier Level Table A, or section A above, the line should be denied with EOB 318.

3. If the modifier is a valid one, determine whether it is applicable to the procedure

code. To do so, find the Modifier Level in the OWCP Fee Schedule book for the procedure code. If the modifier used by the provider is not present in the appropriate table, the line should be denied with EOB 318.

THOMAS M. MARKEY
Director, Division of Federal
Employees' Compensation

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

FECA CIRCULAR NO. 98-12 September 30, 1998

SUBJECT: Selected ECAB Decisions for October - December, 1997

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

Included in this FECA Circular are summaries on idiopathic versus unexplained falls, rescissions of acceptance decisions, a decision on the compensability of suicide, and termination for refusal of suitable work. Should you find, upon reviewing a decision summary, that it affords guidance in a topic that you are addressing, do not fail to avail yourself of the ECAB decision in its entirety for your thorough review.

The ECAB decision summary for the fourth (July through September) quarter of 1997 will be issued shortly.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

IDIOPATHIC VERSUS UNEXPLAINED FALL

Jeffrey P. Werstler, Docket No. 96-314, October 28, 1997
Gary Pelzer, Docket 96-202, Issued November 21, 1997

In the Werstler case, the Board's decision emphasizes the extent of the Office's burden to support a finding that the employee's injury was caused by an idiopathic fall.

The claimant was a 36 year-old window/distribution clerk who suddenly blacked out and fell to the ground, suffering a fractured skull as he was working at the cashier's window. The employer controverted the claim, contending that the incident should be considered an idiopathic fall and as such was not in the performance of duty. There was a witness statement from a coworker describing the claimant as unresponsive while laying on his back on the floor, and indicating that a customer had told the emergency personnel that it appeared to have been a seizure.

The Office obtained another witness statement via a phone conference some six weeks after the occurrence from a coworker claiming to have witnessed the entire incident. The memorandum of conference was sent to the claimant along with a letter requesting medical evidence relative to the employment incident. After some time a medical report was received which confirmed that the claimant did indeed have a history of seizures, but failed to provide anything specific with regard to the incident at work in which the claimant apparently had a syncopal episode. An office medical advisor offered the opinion that the incident was most likely caused by the claimant's seizure disorder. The Office subsequently denied the claim for benefits finding that the claimant's injuries were the result of an idiopathic fall and as such were not covered under the FECA.

The Board found that the Office had not met its burden to establish that the injury was caused by an idiopathic fall and reversed the Office's decision. It held that the fact that the claimant had a history of seizure disorder which raised the likelihood that this injury was caused by an idiopathic condition was not sufficient to establish that this fall was caused by the seizure disorder which was idiopathic to the claimant. Moreover, the Board held that the evidence was insufficient to support that this particular employment incident was caused by an idiopathic condition. The Werstler decision illustrates that just the same as in intoxication and willful misconduct cases, the Office has the burden to prove affirmatively that the idiopathic condition was the proximate cause of the injury.

In the Pelzer decision, the Board affirmed the Office's finding that the evidence of record failed to support that the injury occurred in the performance of duty.

The claimant filed a notice of injury indicating that while standing at the time clock his knees buckled, he fell backward, and he injured his back and right knee. A medical report dated four days after the occurrence indicated that the claimant suffered from a "strange generalized myopathy" which prevented him from standing or walking "for any length of time without his limbs giving way." Upon requesting additional evidence from the claimant's treating physician and any information referring to previous similar symptoms or illnesses, the Office received a report from a board-certified internist who was also a psychiatrist and neurologist. The specialist's report revealed that the claimant was a patient being followed in his clinic for polymyositis which caused severe proximal weakness making it unsafe for him to use public transportation. Thereafter the first physician's report indicated that the claimant's strange myositis involved weakness which made it risky for him to travel alone. Both physicians indicated that they had advised the claimant to stay off work until his condition improved. Even though the claimant's factual statement responded that he had never experienced any similar disability or symptoms before, the Board affirmed the Office's decision. The Board clearly gave the deciding weight to the medical evidence, stating:

> The reports identify appellant's nonoccupational, preexisting condition and therefore, tend to support that a personal nonoccupational pathology caused appellant to fall on July 8. . . None of the reports causally relate appellant's condition to any employment factors. Moreover, the factual evidence indicates he was standing by the time clocks on the second floor, his knees buckled and he fell backward and directly to the floor. There is no evidence indicating this fall was caused by intervention of or contribution by any employment-related factors, i.e., he did not strike any object, other than the floor, during the course of his fall at work on July, 1995.

In distinguishing this decision (<u>Pelzer</u>) from <u>Werstler</u>, above, the claimant did not lose consciousness, he described what caused his fall, and the medical evidence was unequivocal in confirming that the claimant's underlying, preexisting condition would cause his limbs to give way. Moreover, the claimant's work injury was fully explained by his idiopathic condition of myositis.

RESCISSION OF ACCEPTANCE - REVERSALS

<u>Wiley Richey, Docket No. 94-2367, Issued November 7, 1997</u>
<u>William H. Nolan, Docket No. 95-1358, Issued October 17, 197</u>

The <u>Richey</u> case was that of a claimant who alleged a myocardial infarction precipitated by physical exertion while at work in April of 1980. The Office originally denied the case in 1981 based on the opinion of an Office medical advisor that the claimant had not sustained a myocardial infarction and that his disability was the result of his nonemployment related atherosclerotic cardiovascular disease. The Board later directed the Office to resolve the conflict between the claimant's attending internist and the Office medical advisor by using a referee

specialist. The case was subsequently approved and the claimant placed on the periodic roll as of May 1, 1984.

After many years had passed, the attending internist continued to support ongoing total disability as caused by the myocardial infarction of 1980. Instead of obtaining evidence to determine the extent and degree of continuing work related disability, if any, the Office again asked a second-opinion specialist questions regarding whether the claimant had in fact sustained a myocardial infarction in 1980. The second-opinion specialist, in reports of June 1993, found that the claimant did not sustain a myocardial infarction in 1980, and that the claimant's disability was related to his nonemployment related coronary artery disease. Another cardiologist was asked to act as referee specialist to resolve the conflict between the claimant's physician and the second-opinion specialist. The impartial specialist found that the claimant had not suffered a myocardial infarction in 1980 and that his current disability was caused by his preexisting atherosclerotic cardiovascular disease. She stated that her opinion was based on review of the medical records from 1980 and the notes from her examination of the claimant. The Office terminated benefits effective May 1, 1994.

The Board found that the Office's decision was improper on two grounds, 1) it constituted a termination without sufficient medical evidence to meet the Office's burden, and 2) it constituted a rescission of an acceptance without meeting the criteria for rescinding an acceptance. With regard to the termination, the Board found that the Office had improperly sought a referee examination to resolve a conflict it had addressed ten years before with a referee examination. The Board also pointed out that there could not possibly be a conflict between the previous referee specialist and the current second-opinion physician in the sense described in the FECA, as neither of these physicians was a physician for the appellant (both were engaged by the Office). Therefore, the Board stated that the physician that had been contracted was not acting as an impartial specialist on the question of whether the claimant suffered a myocardial infarction, and her report was not entitled to special weight. As such the referee specialist's reports were insufficient to meet the Office's burden to terminate benefits. In addition the Office's decision constituted a rescission of an acceptance without sufficient justification. The Board pointed out that in order to rescind the acceptance of a claim, the Office must show that its decision was based on new evidence, legal argument, or rationale. In this case the referee acknowledged that she had used the April 30, 1980 report of the attending physician to arrive at her conclusion that the claimant did not suffer a myocardial infarction, and that his present medical condition was not related to his federal employment. In essence, no new evidence was available, and no new legal argument or rationale had been provided to justify rescission of the acceptance. The Board pointed out that the referee examiner had stated that she relied on medical evidence which was in the record when the Office initially resolved this question, and noted that the referee specialist had merely arrived at a different conclusion looking at the same evidence. The Board, therefore, reversed the Office decision in Richey.

In Nolan, the case had been accepted in 1989 for the condition of cold injury to the left foot

(frostbite). In March of 1990 two second-opinion physicians reported that they found no organic disease, and the Office medical advisor reported that there was no evidence that the claimant had ever had a frostbite, speculating that his neurologic findings were suggestive of a neuropathy, nerve entrapment, or even lumbosacral disease. The Office declared a conflict in medical opinion necessitating a referral to a board-certified impartial specialist in Neurology in June 1990. The Neurologist found little evidence of a "significant" frostbite injury but stated that "he may have had a mild degree of cold injury," and recommended an electromyogram with nerve conduction studies. An associate neurologist who performed the diagnostic studies indicated that his findings were consistent with mild lateral tarsal tunnel syndrome, but in regard to the frostbite offered that there was "no apparent residual damage from the episode of frostbite" occurring back in January of 1989. The Office subsequently rescinded the acceptance of the case.

The Board reversed the Office's decision holding that it had improperly rescinded the acceptance of the claim.

> To justify rescinding its acceptance of a claim, the Office must show that it based its rescission on new evidence, legal argument or rationale.

In this instance, the Office based its decision on new evidence. However, the new evidence failed to justify the Office action. Neither the physician whom the Office engaged to resolve the conflict in medical opinion, nor his associate made any statement in their reports which indicated that the original decision to accept the case was in error. They both acknowledged that the claimant may have had a mild frostbite initially, but stated that there was currently no evidence of residual damage from this previous injury. The Board pointed out that even though these reports would have constituted the weight of the medical opinion evidence, it did not support or justify the action of rescinding the claim. As such, the Office failed to meet its burden of proof to rescind the acceptance of the claim.

SUICIDE: CHAIN-OF-CAUSATION TEST

<u>Sharon Yonak, widow of Nicholas Yonak, Docket no. 96-471, Issued December 23, 1997</u>

In this case, the Board found that the evidence of record was insufficient to establish the suicide was causally related to the decedent's federal employment, or to his employment injury sustained some eight years earlier. The Board discussed the type of evidence needed in order to establish a suicide as work-related.

In support of her claim that her husband's suicide was caused by his employment injury or its residuals, the widow submitted a letter from her attorney, reports from the decedent's treating physical medicine and rehabilitation specialist, statements from two of the decedent's coworkers (written 3 years after the suicide), and a suicide note. Earlier, the coroner's report had stated that the employee had been depressed over the past two weeks because of problems at work and severe back pain. The police report indicated that the decedent had told his wife that he felt

goofy and wanted to go to the hospital, and that he had previously considered suicide but could not do it. All of the documentation submitted was supportive of the idea that the decedent had been unhappy with his work situation, stating that he was forced to work outside of his prescribed work limitations, and that this caused him to experience increased pain. Also, it was learned from the suicide note that the employee had suggested to his widow that she file a suit against the Postal Service for the way they treated people and kept "fooling" with his job. In the note he claimed that his back hurt him whenever he overdid anything and that the Post Office did not care.

On the other hand, there was a statement from the decedent's supervisor written the same month as his death. This statement indicated that the supervisor had been aware of the decedent's complaints of back pain after standing too long, that he remembered that the decedent's work prior to his injury had been excellent and highly productive, that he had advised the employee that he could do a sit-down job of repairing damaged mail for as long as he needed the rest from standing, and that the decedent essentially had "carte blanche" to rest or sit down for "periods up to his discretion" whenever the floor work became too much for him.

On affirming the Office's decision, the Board noted that Section 8102(a) of the FECA provides that death resulting from an injury while in the performance of duty shall be afforded coverage, unless the death or injury is caused by the employee's intention to bring about harm to himself. Even though the statute seems to automatically preclude compensation for suicide, the Board pointed out that the Office has adopted the chain-of-causation test for determining whether an employee's suicide is compensable under the Act. The chain-of-causation test makes a suicide compensable when a work injury produces mental derangement and the mental derangement produces the suicide. According to Larson's *Workmen's Compensation Law,* the suicide must be traced directly to the work injury. If there is no work-related injury that eventually leads to the suicide, or if the death can be attributed to nonemployment influences, the suicide is not compensable. The FECA Procedure Manual's guidelines for the development of evidence in suicide claims state that for a suicide to be compensable, the chain of causation from the work injury to the suicide must be unbroken. Thus, if the evidence suggests the existence of other factors in the employee's life such as personal problems (e.g., addiction or substance abuse), family problems (e.g., marital or financial difficulties), or non work-related injuries, the Office must develop such factors to determine what effect, if any, they had in causing the suicide, and whether they constitute independent intervening factors sufficient to break the direct chain of causation from the injury to the suicide. According to Larson:

> If the sole motivation controlling the will of the employee when he knowingly decides to kill himself is the pain and despair caused by the injury and if the will itself is deranged and disordered by the consequences of the injury, then the employee's exercise of will in taking his life seems to be in the direct line of causation.

In the instant case the Board held that the claimant-widow failed to establish that the employment injury, in a natural and continuous sequence, unbroken by any new or independent causes, produced the employee's death and that without the injury, the death would not have occurred. The Board stated that in fact it was the claimant's burden to prove that her husband's death by suicide was causally related to factors of his federal employment. In addressing the evidence, the Board pointed out that the decedent's specialist's opinion was provided some three years after the suicide and was speculative. The opinion stated that the decedent's increased work activity in excess of his physical restrictions <u>would</u> certainly have increased his pain and <u>could</u> certainly lead to psychological stress and depression resulting in suicide. However, this specialist had last seen the employee some four months prior to the suicide, at which time he approved the limited duty job the claimant was to start working, and found the physical examination to be normal. Furthermore, during the period that the decedent allegedly suffered the increased pain due to overdoing it at work, he never sought medical treatment for his symptoms, nor is there any evidence that the employee was ever treated for stress or depression. The Board also noted that the statements provided by the decedent's coworkers were some 3 years after the incident and described severe pain in the base of the decedent's neck, with no explanation of how this could be related to the accepted lumbar disc condition.

The Board held that the decedent's supervisor's statement describing the conditions of the work situation and the suicide note itself were far more contemporaneous and, therefore, more probative than the affidavits of coworkers or a medical opinion provided three years after his death. In affirming the Office's decision, the Board found that, overall, the evidence of record did not substantiate that the employee killed himself because of his work-related condition.

REFUSAL OF SUITABLE WORK - PENALTY PROVISION FECA 8106(c)

<u>Gerald R. Willman, Docket No. 95-2810, Issued October 9, 1997</u>

This case is an example of what the Office must do to meet its burden to terminate benefits for refusal of suitable employment.

The employing agency offered the job of office clerk to an employee who had formerly been an aircraft mechanic. The employer advised the claimant of the duties and physical requirements of the position, while advising him that if the Office found the position offered to be suitable, he would have to accept the job or lose his compensation benefits. The claimant advised the employer within the 15 days allotted that he was refusing the job. He stated that his refusal was because he had heard that the job would not last any longer than a year, and that the only benefits provided would be sick leave. The following day the claimant's physician prepared a report indicating that the claimant could perform the work of the position offered and that the requirements were fully within his physical restrictions.

Subsequently, the Office advised the claimant in writing that it found the position to be suitable, that the position was still available, and that he had 30 days to accept the position or to provide

valid reasons justifying his refusal to do so. Within a week the claimant responded that he would not accept the offer because he needed to learn whether the job was temporary and whether it offered any benefits. He also offered that his specialist was having him get an MRI. The Office let the claimant know that his reasons for refusal were not valid and that he had not substantiated that his medical condition had worsened or that he was not able to perform the duties of the job offered. The Office again advised that the job was still available and that this time he had 15 days to respond. The claimant subsequently refused the job again stating that a job that lasted only a year was temporary. The Office terminated the claimant's benefits on the grounds that he had refused suitable work.

The Board noted that the Office has a specific burden to discharge when it terminates benefits under Section 8106(c) of the FECA for refusal to accept suitable employment. It found that the Office had properly discharged its burden before terminating compensation in this case by affording the claimant due process. At the same time the Board noted that the Regulations at 20 CFR 10.124(c) provide that the claimant also has a burden to show that his failure to work after suitable work is offered was reasonable or justified. However, the description above clearly indicates that the claimant failed to show that the reasons given justified his refusal. A position which will last one year or more cannot be considered temporary, and the medical evidence of record supported that the duties were well within the claimant's physical limitations.

FECA TRANSMITTALS (FT)--INDEX

FT 98-01 Checklist, Federal (FECA) Procedure Manual (11/97A)

FT 98-02 Revisions to Chapter 2-0400, File Maintenance and Management, and Chapter 2-1000, Dual Benefits (11/97B)

FT 98-03 Revisions to Chapter 2-0401, Automated System Support for Case Actions (11/97B)

FT 98-04 Release of New Chapter 2-0601, Disability Tracking and QCM Tracking Systems; Revision to Chapter 2-0401, Automated System Support for Case Actions; Revision to Chapter 2-1500, Recurrences; and Revision to the List of Chapters (01/98B)

FT 98-05 Revision of Chapter 2-0500, Conferencing, Chapter 2-700, Death Claims, Chapter 2-800, Development of Claims, and Chapter 2-0802, Civil Employee, Part 2 - Claims, Federal (FECA) Procedure Manual(05/98)

FT 98-06 Revision to Chapter 0-0100, Introduction to FECA and DFEC (10/98A)

FECA TRANSMITTAL NO. 98-01 September 30, 1997

RELEASE - CHECKLIST, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 98-01 September 30, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

This release transmits the current checklist for the Federal (FECA) Procedure Manual. The checklist is a comprehensive accounting of all Procedure Manual pages issued as of July 25, 1997. The previous checklist, issued November 20, 1996, and all transmittal sheets through No. 97-20 may be discarded. The current checklist should be retained at the front of the Procedure Manual, with transmittal sheets after No. 97-20.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
Previous checklist and FECA transmittal sheets through No. 97-20			Current checklist		

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

Distribution: List No. 1--Folioviews Groups A and D
(Claims Examiners, All Supervisors, District Medical Advisers, Systems

Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA TRANSMITTAL NO. 98-02 **December 1, 1997**

RELEASE - REVISIONS TO CHAPTER 2-0400, FILE MAINTENANCE AND MANAGEMENT, AND CHAPTER 2-1000, DUAL BENEFITS, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 98-02 December 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Paragraph 7c of PM 2-0400 is revised to allow for use of an overnight delivery service when sending cases from one office to another.

In paragraph 8 of PM 2-1000, several references to obsolete Form CA-687 have been removed. Elections from the Department of Veterans Affairs should be obtained by narrative letter.

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

THOMAS M. MARKEY
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Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0400	i, 5-6	2	2-0400	i, 5-6
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FECA TRANSMITTAL NO. 98-03 **December 1, 1997**

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

FECA TRANSMITTAL NO. 98-03 December 1, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

A variety of changes are made to this chapter, as follows:

References to the short-term roll and code PV have been removed in accordance with FECA Bulletin 97-04. Specifically, paragraph 7 has been modified, paragraph 9b(2) and the second half of paragraph 9b(4) have been removed, and the subparagraphs have been renumbered.

In light of the recent revisions to PM 2-1400, the term "notice of decision" has been added to "compensation order" in paragraphs 9a(4) and 9c(1), and in 9c(2) the term "formal decision" has replaced "compensation order".

In paragraph 9a(4), the amount payable for medical bills without formal adjudication has been changed to $1500 in accordance with current procedures.

Material about automated tracking of reopened cases which were originally closed short form has been added to paragraph 9e. This material was originally published in FECA Bulletin 93-10.

Finally, paragraph 10 has been modified to reflect the contents of FECA Bulletin 93-11.

The balance of the chapter has been repaginated.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FECA TRANSMITTAL NO. 98-04 **January 28, 1998**

RELEASE - RELEASE OF NEW CHAPTER 2-0601, DISABILITY TRACKING AND QCM TRACKING SYSTEMS REVISION TO CHAPTER 2-0401, AUTOMATED SYSTEM SUPPORT FOR CASE ACTIONS; REVISION TO CHAPTER 2-1500, RECURRENCES; AND REVISION TO THE LIST OF CHAPTERS PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 98-04 January 28, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

This chapter incorporates into the PM the contents of FECA Bulletins 97-02, 95-13, 94-24, 94-11, and 93-10 insofar as those contents are still current. While the material concerning recurrences could logically have been added to PM 2-1500, the close relationship between the Disability and QCM Tracking Systems represented a stronger argument for keeping the discussion of both systems in one place.

References to the new chapter have been added to the first paragraphs of PM 2-0401 and PM 2-1500.

The List of Chapters is revised to include the new chapter.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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Remove Old Pages			Insert New Pages		
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2	List of Chapters		2	List of Chapters	
	2-0401	i, 1-2		2-0401	i, 1-2
				2-0601	i, 1-14 Ex. 1-2
	2-1500	i, 1-2		2-1500	i, 1-2

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

FECA TRANSMITTAL NO. 98-05 **June 2, 1998**

RELEASE - REVISION OF CHAPTER 2-0500, CONFERENCING, CHAPTER 2-700, DEATH CLAIMS, CHAPTER 2-800, DEVELOPMENT OF CLAIMS, AND CHAPTER 2-0802, CIVIL EMPLOYEE, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 98-05 June 2, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-0500, a reference to Exhibit 1 which should have been deleted with the actual exhibit (see FECA Transmittal 97-19) is removed from paragraph 7.

Paragraph 10 of PM 2-0700 is revised to reflect the ECAB's holding in Clyde Stevenson (Donna R. Stevenson), Docket No. 95-3016, Issued February 4, 1998. The Board held that compensation was payable to a grandchild even though the widower was receiving benefits as well. A sentence has been added to paragraph 10b stating that siblings, grandparents, and/or grandchildren may receive compensation even if a widow, widower and/or children are receiving compensation as long as the total percentage does not exceed 75%. Also, the phrase "(if one or more of this class of people are the only survivors)" has been removed from paragraph 10a(2)(a). Finally, the definition of "grandchildren" in paragraph 10 has been rephrased.

In PM 2-0800, a new paragraph 14, Reopening Short-Form Closure Cases, has been added to reflect some of the material first published in FECA Bulletin 94-5.

In PM 2-0802, a new paragraph is added to address the status of contract observers on vessels, as discussed in FECA Bulletin
97-13.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
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	2-0800	i		2-0800	i, 15
	2-0802	i-ii 19		2-0802	i-ii 19-20

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

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

FECA TRANSMITTAL NO. 98-06 **September 30, 1998**

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

FECA TRANSMITTAL NO. 98-06 September 30, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 2 is modified to reflect the current telephone and fax numbers for the Jacksonville and Denver District Offices. Also, the new telephone number for the Branch of Hearings and Review is shown (the fax number remains unchanged).

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
0	0-0100	i Ex. 1, p. 3 Ex. 2	0	0-0100	i Ex. 1, p. 3 Ex. 2

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

OWCP BULLETINS (OB)--INDEX

OB 98-01 Coding of Vocational Rehabilitation Bills (07/98B)
Attachment 1
Attachment 2 (Link to Image)
Attachment 3 (Link to Image)

OB 98-02 Prior Authorization of Field Nurse Services

OWCP BULLETINS--TEXT

OWCP BULLETIN NO. 98-01

Issue Date: July 1, 1998

Expiration Date: June 30, 1999

Subject: Coding of Vocational Rehabilitation Bills

Background: At present, no service code is necessary for processing vocational rehabilitation bills. As a consequence, all FECA vocational rehabilitation bills suspend for verification that the services have indeed been authorized, and that the authorization amount has not been exceeded. Because of the requirement for the separation of functions, the Rehabilitation Specialist in charge of the case cannot directly approve a particular bill for payment.

To streamline the processing of Rehabilitation Counselor (RC) bills, increase the RS's ability to monitor and control authorization amounts, and maximize the data recoverable from the automated system, a prior authorization mechanism is being incorporated into the Division of Federal Employees' Compensation's (DFEC) bill processing system.

This prior authorization mechanism allows the RS to authorize RC services for each case for a specific range of dates and for a specific dollar amount. Incoming bills are keyed into the system using a set of service codes described below. Bills that conform to the authorization parameters are paid and services outside the authorized date range or dollar amount are suspended for resolution. The system will determine whether the incoming bills exceed the authorized amount by totaling the RC services previously paid according to the on-line BPS history and the bill being processed, and comparing this figure with the authorized amount. This calculation will be subject to the following constraints: (1) only services paid to a provider classified under Provider Type U will be considered, and, (2) the program will sum the paid services found in the district office’s bill pay history, which contains records of the bills paid during approximately the previous year. Other rehabilitation bills will be edited for dates of service against the authorized dates.

Because of these restrictions and because of the need to consider cases in progress, blanket authorizations for $5000 will not provide adequate control, and cannot now be introduced into the system. To maximize the efficiency and accuracy of the prior authorization mechanism,

district offices must follow the procedures detailed below.

Purpose: To transmit procedures for the prior authorization of vocational services and the processing of bills in the FECA bill system.

Applicability: Regional Directors, District Directors, Supervisory Claims Examiners, OWCP Rehabilitation Specialists, and bill processing personnel in FECA District Offices.

Action:

1. The rehabilitation counselor service authorization procedures will be implemented on or about July 15th. To prepare for the orderly transition, the RS should:

a) Ensure that all RCs and only RCs appear in the Provider File only under provider type U. To assist in this task, a report of all the providers under provider types C, U, V, and W was forwarded to all district offices on April 9th. Once the RS determines the specific changes, additions and deletions to be made to the file, the staff person responsible for the Provider File maintenance can input all changes. As of July 15th, field rehabilitation counselors must appear only under provider type U. All training facilities should be provider type V. Any other active rehabilitation service provider should be assigned provider type W. Provider type C will be obsolete.

b) Forward the DPPS Notice No. 8 to all active rehabilitation counselors (RCs) in the district, advising them of the new coding and billing requirements and allowing 15 days for an answer. A counselor who refuses to sign and return the statement acknowledging receipt and agreement to submit bills in accordance with the new procedure within the specified time period can be removed from the rotation. After implementation, RCs who continue to submit incomplete or erroneous bills after being instructed once are subject to a warning letter.

2. The rehabilitation authorization program is available as Option 39 under FECS001, Case Management Menu. It requires the input of a FECA case number, the authorized date range and the dollar amount authorized. (Instructions on how to use the program will be transmitted separately). The RS may enter authorization on new cases. Each district office may select other staff member(s) not associates with bill pay process to perform the data input on prior cases, and they should become familiar with the format of the screen.

3. For rehabilitation cases that are opened on or after 7/15/98, the RS should enter the following in the prior authorization table when the case is opened for RC services:

Claim file number

The date of the OWCP-35 opening the case is input as the "from" date of authorization. The

"through" date is input as two years after the “from” date. The RS should authorize a shorter period of time whenever there is a high probability that the case will be closed in less than two years. The system will suspend bills where dates of services fall outside the range.

c. The dollar amount approved for RC services for one year. This figure may be estimated as the total amount authorized divided by the number of years. For example, if the total amount authorized in the OWCP Form 35 is $5000, the RS should enter $2500 in the dollar amount field.

4. It is not required that "backfill" of authorizations for open cases be done prior to implementation. Bills for these case will suspend for manual review because there is no match in the prior authorization table (Error code 610). The case data can be entered into the prior authorization screen at this point and the bills recycled. To determine the date range and the dollar amount that should be authorized for cases in progress, the RS examines the data in the RH-7 SUMMARY report.

The "from" date assigned to all cases in progress should equal the date the case is opened for services, according to the RH-7 Summary report. The RS should assign a "through" date based on the present status of the case, and the authorization period for all services. While tuition and other bills do not require service codes, they will be edited for dates of service against the authorization.

To determine the dollar amount to be introduced in the authorization program, the RS should estimate an average annual expenditure. An estimated average year’s expenditure can be obtained by adding the amounts under Plan Development (U) and Placement (W) in a recent RH-7 report and dividing this figure by the number of years of services. (If the estimated amount needed for the coming year plus the amount already spend exceeds the original written authorization to the counselor, the RS must use Forms OWCP-24 and OWCP-16 to formally authorize the additional money.)

5. Offices should continue to receive, screen, route, number and batch rehabilitation bills according to established practices.

6. However, as of July 15, all RC bills MUST contain the alphanumeric service codes detailed in Attachment 1 to describe the services rendered.
In addition, the bills must contain the dates of service, individual service charges, the provider’s EIN, name and address, and the claimant’s claim file number, name and address. Suggested billing formats are depicted in Attachments 2 and 3.

Instructions on how to input bill data onto the screen will be transmitted separately.

During the initial "backfill" period and later, bills may suspend or
be denied for a variety of reasons including: lack of essential data such as rehabilitation

procedure codes, claimant or provider information; eligibility issues; or duplicate edits. Bills suspended for these and other reasons unrelated to rehabilitation should continue to be resolved in the usual manner.

8. Once each case has been given an initial on-line authorization, bill resolvers will notify the RS through a designated supervisor (to preserve separation of function) when bills fail Edits 609, 610 and/or 620 because the dollar amount has been exceeded or the date of service fall outside of the authorized time period. The RS uses the process described under 4a-b of this bulletin to arrive at the dollar amount and/or time period to be authorized and enters these data in the rehabilitation authorization table.
The RS can modify the existing dollar amount and "from" date or add a new date range. Once this is completed, the bill resolver is notified and the bill can be recycled for final processing.

9. It is suggested that when approving a new or revised plan, the RS review the authorization and make any needed changes.

10. When a case is closed for rehabilitation services, the RS changes the "through" date in the rehabilitation authorization table to the closure date. This will prevent the payment of services rendered after the case is formally closed.
11. If an office is using a counselor as a screener, the RC's provider type code should be changed to W, and bills should be processed as they are now, without service codes. When the counselor resumes work as a field counselor and accepts cases, the code is changed to U and service codes must be entered.

Disposition: This bulletin is to be retained until the expiration date, until canceled or superseded, or until incorporated into the OWCP Procedure Manual, Part 3.

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

Attachments (3)

Attachment 1

Code	Description
VR001	Professional time of RC - counseling, placement, monitoring, testing, transferable skills analysis, job seeking skills training - prior authorization required
VR002	Non-professional time, by RC, or clerk/typist under the RC's supervision, travel, waiting - prior authorization required
VR003	Testing or transferable skills analysis performed by other than RC (when RC has paid the vendor and submits to OWCP original receipt and bills for reimbursement) - prior authorization required; Testing or transferable skills analysis performed by other than RC (when RC does not pay vendor); vendor submits original and duplicate bill and report directly to OWCP for payment - prior authorization required
VR004	Mileage associated with all travel - prior authorization required
VR018	Long distance telephone calls, Parking, Tolls, and other Itemized Expenses

Attachment 2 (Link to Image)

Attachment 3 (Link to Image)

OWCP BULLETIN NO. 98-02

Issue Date: September 15, 1998

Expiration Date: August 14, 1999

Subject: Prior Authorization of Field Nurse Services

Background: The DOL field nurse procedure codes (NIPOO, NIPO1, NIAOO, NIAO1, NITRA and NIPTC) allow the processing of field nurse (FN) services through the automated Bill Processing System (BPS). However, the BPS does not contain edits or checks to verify that the nurse services have been authorized or that particular services fall within the time period and/or the dollar amount of the authorization. At present, the staff nurse (SN) must manually review bills to ensure that the charges have been authorized and to verify that the costs of the case do not exceed the established case maximum.

To streamline the processing of FN bills, increase the SNs ability to monitor and control authorization time periods and amounts, and maximize the data recoverable from the automated system, a prior authorization mechanism is being incorporated into the Division of Federal Employees' Compensation's (DFEC) automated system.

As designed, the prior authorization mechanism allows the SN to authorize FN services in a case for a specific range of dates and dollar amount. Incoming bills are keyed into the system and those that conform to the authorization parameters are paid, while bills that do not conform are suspended for review.

This Bulletin details the procedures for the prior authorization of FN services, including the resolution of suspended bills.

Purpose: To transmit procedures for the prior authorization of FN services and the processing of bills through the BPS.

Applicability: Regional Directors, District Directors, Supervisory Claims Examiners, FEC Staff Nurses and bill processing personnel in FECA District Offices.

Action:

1. The prior authorization mechanism is to be used for FN services exclusively. This enhancement is not applicable to services rendered by the "telephonic case manager" (TCM) which are coded with NC procedures. A new long distance phone call reimbursement code for the TCM has been developed to maintain a separation of FN codes (NI) and TCM codes (NC). This new telephone reimbursement code for the TCM is NCPTC.

2. The FN authorization program is available as Option 40 on the Case Management Menu. It requires the input of a FECA case number, the authorized date range and dollar amount. (Instructions on how to actually use the program will be transmitted separately). The SN may enter the authorizations on all cases. However, to assist in the process, each district office may select other staff members not associated with the bill pay process to perform the data input, and they too, should become familiar with the format of the screen.

3. For FN cases that are opened on or after 8/15/98, the SN should enter the following in the prior authorization table:

a. Claim file number

b. The "from" date is the date the FN is assigned the case or the date the "B" is coded into the N/RTS. The "to" date should reflect the usual 180 days that an FN is assigned to a case (120 days on intervention and 60 days follow up on the RTW). The SN may authorize a shorter period of time whenever there is a high probability that the case will be closed in less than 180 days. Conversely, when the FN time needs to be extended past the initial "to" period, it may be overwritten or "blanked out" and the new date may then be entered. Since there is no historical backup on this data, a screen printout should be made and kept in the file prior to overwriting the end date.

c. The dollar amount approved for FN services should reflect the maximum dollar amount per case which is $4,000. This is based on a FN hourly rate of $65.00. As with the date range, if FN hourly reimbursement rate is lower than the $65.00, the SN may enter a lesser dollar amount. If on the other hand, at the time of authorization, the SN enters an amount greater than $4,000 because it is recognized that the $4,000 maximum will not cover the duration and complexity of the case (catastrophic case), an error message will appear "$4,000 Maximum Exceeded - Amount Justified? Continue? [Y/N]." The SN then needs to respond [Y].

4. Once each case has been given an initial on-line authorization, bill resolvers will notify the SN through a designated supervisor (to preserve the separation of function) when bills fail Edits

609, 610 and/or 620 because the dollar amount has been exceeded or the date of service falls outside the authorized time period. The SN uses the process described in 3. a-b of this bulletin to arrive at the dollar amount and/or time period to be authorized and enters these data in the nurse authorization table. The SN may modify the existing dollar amount and "from" date or add a new date range. Once this is completed, the bill resolver is notified and the bill can be recycled for final processing.

5. Bills for cases will suspend for manual review when there is no match in the prior authorization table (ERROR code 610). The case data can then be entered into the prior authorization screen at this point and the bills recycled. To determine the date range and the dollar amount that should be authorized for cases in progress, the SN should evaluate the data in the NI reports and the Case Status Query report from the N/RTS.

a. The "from" date assigned to all cases in progress should equal the date the case is opened for services, according to the NI Summary report. The SN should assign a "through" date based on the present status of the case, and the time frame left on the case. For example if the case is currently in "B" status, the through date should reflect at least 120 days from the date the case is entered in the prior authorization table. If however the case is already in the "H" status, a 60 day period between the from and through dates is all that is needed. Since you can always overwrite the ending date, it is safer to err on the conservative side.

b. To determine the dollar amount to be introduced in the authorization, the SN should estimate the monthly charges of the FN and enter that amount based on the period of time left on the case.

6. Offices should continue to receive, screen, route, number and batch FN bills according to established practices.

7. Bills may suspend or be denied for a variety of reasons including: lack of essential data such as procedure codes, claimant or provider information, eligibility issues, or duplicate edits. Bills suspended for these and other reasons unrelated to nursing service issues, should continue to be resolved in the usual manner.

8. When a case is closed for FN services, the SN changes the "to" date to the closure date. This will prevent the payment of services rendered after the case is formally closed.

Disposition: This bulletin is to be retained until the expiration date, until canceled or superseded, or until incorporated into the OWCP Procedure Manual, Part 3.

Diane B. Svenonius

Director, Division of
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OWCP CIRCULARS (OC)--INDEX

OC 98-01 Reimbursement Rates for Travel (10/98A)

OWCP CIRCULARS--TEXT

OWCP CIRCULAR NO. 98-01 **September 22, 1998**

Subject: Reimbursement Rates for Travel

Background: Effective September 8, 1998 the mileage rate for reimbursement to federal employees traveling on official duty by privately-owned automobiles was changed to 32.5 cents per mile by the General Services Administration. The rate for travel by motorcycle is 26 cents per mile. As in the past, these rates are applied to injured workers (IWs) involved in approved rehabilitation activities (under the maintenance allowance and prior-authorized travel to and from a residential facility), rehabilitation counselors (RCs) under Form OWCP-35 and specific authorization by the rehabilitation specialist (RS) using Forms OWCP-16 and OWCP-24, and Contract Field Nurses (FNs) under the direction of the Staff Nurses (SNs).

Effective immediately all IWs, RCs and FNs should be advised of the new rates in effect and date of applicability. Appropriate measures should be undertaken to allow for adjustment of the mileage requests from IWs who traveled to and from residential facilities under RS approval and RCs and FNs during the course of their usual work, since September 8.

The rates were published in the September 8, 1998 Federal Register page 47438, No. 173.

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OWCP TRANSMITTALS (OT)--INDEX

OT 98-01 Release of new Chapter 1-300, Records Management (09/98A)

OT 98-02 Revision to Chapter 3-100, Introduction; Chapter 3-200, Services; 3-201, FECA Case Management and 3-300 Referral Development - Part 3 - Rehabilitation, Federal (OWCP) Procedure Manual (01/98A)

OT 98-03 Revision to Chapter 3-400, Case Management (07/98B)

OWCP TRANSMITTALS--TEXT

OWCP TRANSMITTAL NO. 98-01 September 21, 1998

RELEASE - CHAPTER 1-300, RECORDS MANAGEMENT OWCP PROCEDURE MANUAL

OWCP TRANSMITTAL NO. 98-1 September 21, 1998

EXPLANATION OF MATERIALS SUBMITTED:

This release transmits Chapter 1-300 of the expanded OWCP Procedure Manual. Chapter 1-300 describes The Office of Workers' Compensation's (OWCP) records management plan and the procedures for disposing of written and automated records and data. Information is also included regarding record maintenance. The chapter incorporates program-specific procedures previously described in the three program operating procedure manuals and contributes to efforts to reduce the size of procedure manuals in OWCP.

This chapter is formatted for Folioviews and will be electronically accessible.

DIANE B. SVENONIUS
Director, Division of Planning,
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OWCP TRANSMITTAL NO. 98-02 December 31, 1997

RELEASE - REVISION TO CHAPTER 3-100, INTRODUCTION; CHAPTER 3-200, SERVICES; CHAPTER 3-201, FECA CASE MANAGEMENT AND CHAPTER 3-300, REFERRAL DEVELOPMENT - PART 3 - REHABILITATION, FEDERAL (OWCP) PROCEDURE MANUAL

OWCP TRANSMITTAL NO. 98-02 December 31, 1997

EXPLANATION OF MATERIAL TRANSMITTED:

Chapters 3-100 through 3-300 are revised to incorporate material issued in OWCP Bulletins.

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3	3-201	1-7	3	3-201	1-7
3	3-300	1-13	3	3-300	1-14

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OWCP TRANSMITTAL NO. 98-03

RELEASE - REVISION TO CHAPTER 3-400, CASE MANAGEMENT; PART 3 - REHABILITATION, FEDERAL (OWCP) PROCEDURE MANUAL

OWCP TRANSMITTAL NO. 98-3 June 15, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 3-400 has been revised, incorporating material previously included in Bulletins and Notices, with the assistance of a team of field Rehabilitation Specialists - Deborah Murphy (Jacksonville), DuWayne Smith (San Francisco) and Laura Miller (Dallas).

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