BCT-FY99

This infobase contains a numerical index of all FECA and OWCP Bulletins, Circulars and Transmittals issued in FY 1999, as well as the text of these issuances.

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FECA BULLETINS--TEXT

FECA BULLETIN NO. 99-01

Issue Date: September 8, 1998

Expiration Date: September 7, 1999

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

Background: Effective September 8, 1998, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobiles was increased to 32.5 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, determination has been made to apply the applicable rate to disabled FECA beneficiaries traveling to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

Reference: Chapter 5-0204, Principles of Bill Adjudication, Part 5, Benefit Payments, Federal (FECA) Procedure Manual; Instruction
CA-77, Instructions for Submitting Travel Vouchers; and 5 USC 8103.

Action: Instruction CA-77, Instructions for Submitting Travel Vouchers, has been revised to reflect the indicated rate change. A copy of the revised instructions is attached to this bulletin and may be reproduced at local levels. It will not be necessary to search and locate vouchers processed subsequent to September 8, 1998; however, if inquiry is received, appropriate adjustment should be made. Vouchers being processed for travel periods after September 8, 1998, may be adjusted to reflect this increase.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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

Attachment: Form CA-77, Instructions for Submitting Travel Voucher (Link to Image)

FECA BULLETIN NO. 99-02

Issue Date: May 3, 1999

Expiration Date: May 2, 2000

Subject: Case Management--Medical Queries by Contract Nurses

Background: OWCP nurses, both those working in the field and those working by telephone, assist claims staff in many ways:
by gathering information from employing agencies and medical providers; by helping claimants to understand their medical care and limitations; and by coordinating return-to-work efforts, to name just three areas where they commonly provide assistance.

In their efforts to obtain medical information, some contract nurses take a very active role in posing questions to attending physicians. Such an approach is proper when the questions involve work limitations, expected length of recovery, and prognosis.

However, matters such as the diagnosis, the presence or absence of objective findings, and causal relationship are adjudicatory in nature, and queries addressing such matters may interfere with case management efforts by claims staff, either because they are redundant or because they inadvertently expand the scope of the claim. Therefore, only claims staff should pose such questions.

Reference: Federal (FECA) Procedure Manual Chapter 2-600, subparagraphs 3 and 5

Purpose: To clarify the kinds of information which may properly be requested by contract nurses, and the kinds of information which should be requested only by claims staff

Applicability: Claims Examiners, Staff Nurses, and Supervisors

Actions:

1. Claims Examiners remain responsible for managing claims. They may not delegate this task to OWCP nurses. While it is permissible for OWCP nurses to help claims staff compose questions to medical providers with respect to adjudicatory issues, and for second opinion medical examinations, the Claims Examiner must have the final say in wording these questions.

2. Claims supervisors and the Staff Nurse, as the manager of the contract nurses, should be alert

to statements in letters from contract nurses to medical providers which indicate that contract nurses, rather than Claims Examiners, are managing claims.

In particular, contract nurses should avoid posing questions such as the following:

What is your diagnosis of Mr. X?

Are Mr. X's symptoms related to his occupational trauma on 06/06/98?

When such instances are identified, the Staff Nurse should counsel the contract nurse as to questions which may properly be asked of medical providers and questions which should be avoided.

Attached is a sample notification that can be shared with the contract nurses. The notice emphasizes the general guidelines for types of questions to be posed to physicians.

Disposition: Retain until the indicated expiration date.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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)

Attachment

ATTENTION ALL OWCP CONTRACT NURSES

In reviewing monthly reports of both telephonic and field nurses' services, I have identified a need to share some general guidelines to be used when posing questions to the attending physician.

Questions regarding clarifying work limitations, expected length of recovery and prognosis are not only proper but should be posed in order to obtain a clear picture of the return to work potential. However, questions that relate to either the presence or absence of objective findings and/or causal relationships are adjudicatory in nature. Since repsonses to these questions could inadvertently expand the scope of the claim, these types of questions need to be posed only by the claims examiner.

For example, asking the physician whether "Mr. X's symptoms are related to his occupational trauma on 6/6/98" would not be appropriate. However, posing the question "Will Mr. X's cervical strain result in release to full or part time work activity" captures the real issue of what return to work capacity can be anticipated.

In some cases claims examiners will request your assistance in formulating questions to medical providers which involve adjudicatory issues. You may certainly assist them in phrasing these questions but the final wording resides with the claims examiner.

Thank you for your cooperation on this issue. Please contact me should there be any questions on this matter.

Sincerely,

Staff Nurse

FECA BULLETIN NO. 99-03

CORRECTED COPY

Issue Date: January 27, 1999

Expiration Date: January 27, 2000

Subject: Case Management/ADP: Guidelines for Periodic Roll Management

Background: In FY 1992, the Periodic Roll Management Project (PRMP) began. The PRMP was designed to review a set universe of cases on the long-term disability rolls with an eye toward resolution of these cases. This was a four-year term project, with some district offices (Boston, Jacksonville, San Francisco, and Seattle) beginning in 1992 and completing the project in 1996. Other district offices began PRMP in either 1995 or 1997 and their teams remain active.

Owing to the success of this project, it has become a permanent initiative of the program in FY 1999. Every district office will have permanent Periodic Roll Management (PRM) staff. These examiners will continue to pursue the goals outlined for the PRMP--review and resolution of long-term disability cases.

The performance measure for resolution of periodic roll cases is defined as an entitlement decision that brings some closure to the case. Usually, the entitlement decision would be the result of a full-fledged review by the PRM claims examiner. In cases where there is no change in the entitlement level, this will include at a minimum a second-opinion examination or a directed examination by the attending physician, with specific questions regarding ongoing injury-related disability.

As part of the transition from a project to a permanent initiative, changes have been made to both the composition of the PRM universe, altering it from a set group of cases to a fluid one, and to coding under the Periodic Roll Management System (PRMS). The coding changes will better allow the tracking of program goals.

Reference: FECA Bulletin 95-15

Purpose: To inform all claims staff of updates to PRM universe composition and to the PRMS coding scheme.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel

Action:

1. The base PRM universe will be identified for each district office using all cases on the

periodic roll as of the October 10, 1998 payment except those cases active in QCM (category A or B) which are less than 30 months old.

2. Cases will be added to this universe as follows:

   a. Non-QCM cases placed on the periodic roll will be added to the universe immediately;

   b. Any non-QCM periodic roll case transferred in to a district office will be immediately part of the new owning district office's PRM universe;

   c. Any periodic roll case which is closed, removed (zeroed out) or expired (more than 30 months old) from QCM tracking will immediately become part of the PRM universe.

3. Cases will be removed from the PRM universe as follows:

   a. PRM cases transferred to another district office will leave the prior owning office's PRM universe;

   b. Any PRM case with a new recurrence that is approved, causing it to drop into QCM will leave the PRM universe.

   c. Any case deleted from the periodic roll will be removed from the universe. These should also be tracked in PRMS as discussed below.

4. The System Manager at each District Office will be able to produce a report as frequently as needed to identify cases that have been added to or dropped from PRM per these guidelines.

5. Using the report described in item 4, district offices must manually reassign cases to the appropriate responsible claims examiner or unit on a periodic basis. The National Office is looking at the feasibility of creating new and/or modifying existing programs to automate this case reassignment process.

6. Coding in PRMS has been streamlined, to focus emphasis on the resolution of cases in the PRM universe. While codes for actions not affecting entitlement continue to be available, these codes are optional. All actions which resolve a PRM case, however, must be tracked in the PRMS. Attached is a list of all PRMS codes now available for use. Note that codes for increases in compensation are no longer being used. Additionally, election of OPM benefits is considered a resolution only when it results in termination of all compensation payments, including periodic payments for schedule award. Coding for the conclusion of a schedule award (without further loss of wage earning capacity) has been separated into codes that reflect whether intervention was taken in the case to bring about the resolution. This will assure that the ending of a schedule award, without any action on the part of claims staff, does not count as a resolution.

<u>Disposition</u>: 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)

Attachment

PRMS ACTION CODES

Resolution Codes

Reduction of compensation:

R1 Constructed LWEC
R2 RTW with LWEC
R3 S/A expired with LWEC

Suspension of compensation:

S2 Suspension 5 USC 8123
S3 Suspension 5 USC 8113

Termination of compensation:

T1 Terminated, no continuing IRD
T2 RTW, no LWEC
T3 S/A expired, intervention, no LWEC
T4 Refused suitable work
T5 Death of claimant
T6 Elected OPM with no periodic Schedule Award payments

Case reviewed, no change:

CR No change in entitlement after review

Necessary code, not counted as resolution:

S1 Suspension no 1032
T0 S/A expired, no intervention, no LWEC

Optional Codes

IR Initial Review Done
MN Narrative Requested
MR Narrative Received
SE SECOP scheduled
RF Referee scheduled
VR Referred for rehab
JO Job offer made
PR Pre-reduction sent
PT Pre-term sent
EO Elected OPM

FECA BULLETIN NO. 99-04

Issue Date: November 20, 1998

Expiration Date: November 19, 1999

Subject: Bill Payment/BPS--Medications Which Do Not "Match" Accepted Conditions

Background: The new procedures for processing pharmacy bills have prompted queries about handling "mismatches" between accepted conditions and medications billed. Such "mismatches" may come to OWCP's attention either because the Bill Processing System (BPS) flags the medication as questionable in the case at hand or because a bill has been denied and the claimant or the pharmacy has returned the explanation of benefits (EOB) to OWCP.

In either instance, OWCP must take further action. While some medications may prove to be payable, others will continue to be ineligible for payment or reimbursement. This bulletin describes the actions which bill resolvers and claims staff will need to take in processing bills for medications which do not "match" the accepted condition(s) in the case.

Reference: FECA Bulletin 98-11

Purpose: To describe the actions to be taken when a particular medication does not "match" the accepted condition

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

Actions:

1. Where OWCP has already denied a bill for a "mismatch", the edit code is likely to be one of the following: 734 (therapeutic class is not payable for the accepted condition(s); 738 (the relationship between the therapeutic class and the accepted condition(s) requires manual review); and 746 (the accepted condition is missing from the relationship table).

Edit 734 results in an automatic denial, while edits 738 and 746 result in suspension. The suspension can be overridden if the bill is payable, or set to deny if the bill is not payable.

2. When an EOB letter is returned, and the reason for denial was code 734, an NDC query should be performed. The relationship file has recently been updated, and additional changes will continue to be made periodically. As a result of these changes, a medication that was previously denied may now be payable. Also, if the accepted conditions have been updated, the medication may now be payable.

3. If the bill is now payable, it should be rekeyed. If the bill was originally denied with EOB 738 or 746, and it should have been paid, it should be rekeyed, and the edit suspension overridden. Entry of a note to indicate that the medication is payable should prevent erroneous denials in the future.

4. If the bill is not payable, but experience has shown that the medication is often used to treat the condition in question, the District Medical Advisor (DMA) should be consulted. If the DMA agrees that the medication is properly used to treat the condition, the issue should be referred to Dr. Virginia Miller, OWCP Medical Director, so that modification of the relationship table may be considered.

5. If the bill remains unpayable after these steps have been taken, the Claims Examiner (CE) will need to review the medical evidence in file and/or obtain additional medical evidence to determine whether the medication is correctly used in the case at hand. The Physicians' Desk Reference (PDR) may be consulted to determine the proper use of various medications.

As always, the CE will need to exercise judgment in deciding if a particular medication should be (or continue to be) authorized. The CE should ensure that the accepted conditions accurately reflect the scope and severity of the claimant's injury and update the ICD-9 codes if warranted.

6. If the medical evidence supports payment but is not conclusive, the CE may obtain the advice of a District Medical Adviser. It is not anticipated that second opinion or impartial referrals will be needed to adjudicate such questions.

7. In long-term cases, OWCP may have paid for a questionable medication for many months or years. (By one estimate, over a third of periodic roll cases involve at least one medication where the relevance to the accepted condition(s) is questionable.)

In such instances the CE should add "P99" as a temporarily accepted condition to allow for payment during development of the issue. (This code should also be used to indicate an adjunct condition, and instead of any "placeholder" acceptance codes.)
A note showing that the medication is payable should be placed on the system, as edit 746 will suspend the bill if it is not otherwise payable.

8. If payment is denied, the responsible CE may release a letter decision to that effect. A sample is shown as Attachment 1. It is being added to the Letter Generator system.

9. A claimant who objects to this decision, either in writing or by telephone, should be issued a formal decision with full appeal rights. However, receipt of additional bills for the medication in question will not, by itself, be considered an "objection" to the letter decision. The claimant must actually express disagreement with the letter decision. Any formal decision must be based on the medical evidence of record, not the outcome of relationship editing by the BPS.

10. At present, there is no vehicle for advising injured workers with new claims that pharmacies may bill OWCP directly using the Universal Claim Form, or that injured workers should use Form CA-915 if they are seeking reimbursement of pharmacy expenses. Form CA-1008 is being revised with this information (a copy of the revised form is shown as Attachment 2.) The information will be added to Forms CA-14 and CA-1009 as soon as the forms are revised in conjunction with the program's new regulations.

Disposition: Retain 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 Advisors, Rehabilitation Specialists, and Fiscal and Bill Pay Personnel)

Attachment 1: Form CA-1008

(999) 999-9999

File Number: 11-1111111
Date of Injury: 02/02/1900
Employee: CLAIMANT M. NAME

CLAIMANT M. NAME
000000000000000000000000000000
000000000000000000000000000000
000000000000000000000000000000

000000000000000000000000000000

Dear CLAIMANT M. NAME:

I am writing in reference to your claim for injury on 02/02/1900, which you sustained while employed by the agency identified below. Your claim is accepted for:

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

If your injury results in disability for work or the need for medical treatment, you may be eligible to receive continuation of pay (COP) until you recover or return to light duty, up to a maximum of 45 calendar days. If wage loss continues after the expiration of COP, you are eligible to claim disability compensation on Form CA-7. Bills for medical expenses related to the accepted condition(s) noted above will be processed for payment by this office following proper submission of charges. This includes medications which are prescribed for the accepted condition(s) noted above.

Pharmacies may bill this office directly using the Universal Claim Form. The pharmacy should include the following information: the case file number, the nine-digit tax ID number, the NDC number, the prescription number, the quantity of medication prescribed, the name of the prescribing physician, and the date of purchase. If you request reimbursement, please complete Form CA-915, which is used in addition to the Universal Claim Form. You may obtain Form CA-915 from your employing agency or from this office.

The enclosure, which is entitled "Now That Your Claim Has Been Accepted...", provides information about payment of bills, claims for compensation, and other matters pertinent to your claim.

Sincerely,

NAME OF SIGNER
TITLE

CA1008-1098 Page 1

Attachment 2: Sample Letter--Prescription Bill Denied

Dear NAME OF CLAIMANT:

I am writing in reference to prescription bills submitted in your claim for injury on 02/02/1900, which has been accepted for:

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

All claims for prescription payments must contain a National Drug Council (NDC) code for each drug billed. Each NDC code is an 11-digit number which represents a specific medication, made by a specific manufacturer, of a certain strength. The NDC coding system is used by pharmacies all over the United States.

On receipt of a bill for prescription expenses, the Office of Workers' Compensation Programs (OWCP) compares the NDC code to the medical condition(s) which OWCP has accepted as work-related. Sometimes, this comparison shows that the medication is not one which is properly used to treat the accepted condition.

In your case, OWCP received a bill from NAME OF PHARMACY on DATE OF RECEIPT for NAME OF MEDICATION. The NDC code for this medication, which is 99999999999, does not correspond to your accepted condition of ACCEPTED CONDITION. This means that the medical community does not generally recognize NAME OF MEDICATION as effective or safe to use in treating ACCEPTED CONDITION. For this reason, payment for NAME OF MEDICATION is denied.

This does not mean that your physician has prescribed NAME OF MEDICATION in error, or that you should not take this medication. Of course, NAME OF MEDICATION may be needed to treat some other, condition which is not related to your work, and you should consult your physician before changing the kind or amount of any medication you are taking. You may wish to submit bills for NAME OF MEDICATION to your health insurance carrier for consideration of payment.

If you have any questions, please do not hesitate to contact this office.

Sincerely,

NAME OF SIGNER

TITLE

FECA BULLETIN NO. 99-05

Issue Date: May 17, 1999

Expiration Date: May 17, 2000

Subject: Case File Imaging

Background: In November of 1997, via FECA Bulletin 98-01, a pilot imaging program was implemented to facilitate the maintenance of case files where the physical file was with the Employees' Compensation Appeals Board. Prior to this pilot, all maintenance of cases before the Board was handled by the Branch of Hearings and Review, although the claims examiners in the Branch were not familiar with the cases and often did not have possession of the physical case files.

The pilot has been successful in that it has allowed maintenance of Board cases in the owning District Office, where the staff is better equipped to address the issues that arise. There have been, however, some difficulties in adapting to the imaging technology selected for the pilot. In light of these difficulties, a new prototype imaging system will be selected prior to transitioning to an imaged environment for new cases. Presentation and implementation of this system will commence in May of 1999.

Reference: FECA Bulletin 98-01

Purpose: To describe changes in imaging of cases before the Board.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel

Action:

Effective May 17, 1999, all ECAB requests are to be routed to the National Office for review prior to imaging. The new system will function as follows:

The ECAB will electronically request a docketed case.
District Office staff will transfer the case file to location code T51 (as done prior to the imaging pilot).
National Office staff will review the file to determine whether it will be imaged. This

decision will be based upon the nature of decision at issue in the case and the level of maintenance expected to be needed during its tenure at the Board (the attached chart outlines some general guidelines that may be followed in making this decision, but these guidelines will be applied loosely as necessitated by the judgement of the National Office staff member).

If the case file is not to be imaged, National Office mailroom staff will number the case file and forward it to the Board.

If the case file is to be imaged, National Office staff will forward the case to the FEC Imaging Center for imaging.

Claims Examiners in the Branch of Hearings and Review will once again perform case maintenance on all non-imaged cases. This maintenance will be limited, however, due to the nature of these non-imaged cases. When these cases are returned, as paper files, to the District Office after the Board reaches a decision, they will remain non-imaged and will continue to be handled as paper files. Due to budgetary constraints, it is not foreseen that open cases, including these, will be imaged until FY 2001, when a conversion of paper files may be possible.

District Office staff will remain responsible for maintenance of any imaged case before the Board. This will include holding the case file jacket and CA-800 as outlined in FECA Bulletin 98-01, and imaging all new mail as it arrives in the District Office. National Office mailroom staff will image all documents created in relation to the appeal prior to the return of the paper file to the District Office. When the paper file is returned, it should be associated with the jacket and CA-800 as per current practice. The image file will remain the primary record, again in keeping with current practice.

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

SHEILA M. WILLIAMS
Acting Director for
Federal Employees' Compensation

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

Attachment: Basic Guidelines for Imaging of Cases Requested by the Employees' Compensation Appeals Board (Link to Image)

FECA BULLETIN NO. 99-06

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations: Continuation of Pay

Background: Part C of the Regulations, which includes sections 10.200 through 10.224, has been substantially revised. The revisions are as follows.

INITIAL CLAIM FOR COP:

Section 10.205(a)(3) revises the 90 days in which a person must begin losing time from work, in order to receive COP, to 45 days. Timely submission and adjudication of claims has dramatically improved since the 90-day period was adopted. Therefore, this grace period is no longer necessary to ensure that the injured worker's pay continues uninterrupted. The Program's focus on minimizing lost work time requires early intervention, which can only occur when OWCP is aware that an employee has lost time. The proposed time frame was 30 days, but upon consideration of comments received from various agencies and labor organizations, the time frame in the final rule is 45 days.

Thus, COP is payable only when disability begins, or time is lost for medical care, within 45 days of the date of injury.

While COP has always been appropriately used for medical treatment, a phrase specifying that has been included in section 10.205(a)(1).

Section 10.205(a)(2) clarifies existing practice that if Form CA-1 is not available, another form (CA-2 or CA-7, which contain words of claim) could be used to claim COP. The word "form" in this section does denote an OWCP-approved form, and a letter would not serve the purpose of timely filing.

RECURRENCE:

Consistent with Section 10.205, Section 10.207(c) allows any balance of COP remaining after the injured employee returns to duty to be used for a recurrence of disability, or for medical treatment, which begins within 45 days of the first return to work.

Section 10.207(a) clarifies that Form CA-2a is required to receive COP for a recurrence of disability.

While it does not specifically pertain to the new Regulations, the question has arisen, "When does time begin to toll for using a balance of COP in cases where there is no lost time immediately following an injury?". Various OWCP publications could be read differently on this issue. The Regulations, Procedure Manual, Publication CA-810, and the Resource Book for the Agency Workshop use the terms "work stoppage", "disability", and "lost time" variously in reference to when time begins to toll for using a balance of COP.

To clarify, time lost on the day of injury that is charged to administrative leave is considered a work stoppage, whether the time is used to obtain medical treatment or for disability. If the time away from work is so minimal that no administrative leave is charged, such as a brief visit to the health unit, this is not considered a work stoppage for the purpose of tolling time. Where administrative leave is charged on the date of injury, that constitutes a work stoppage, and the return to work after the administrative leave, whether that be on the date of injury or the following day, is considered the first return to work, and the 45 days for using any balance of COP begins to toll on that date.

MEDICAL EVIDENCE IN SUPPORT OF COP:

Section 10.210(b) reduces the time allowed for the employee to provide the employer with a medical report supporting disability from 10 working days to 10 calendar days, and includes a requirement that the medical evidence contain a statement of when the employee can return to the date of injury job. This is consistent with the emphasis on early intervention.

Section 10.506 allows an employer to contact the employee's physician in writing, for the purpose of monitoring an employee's medical progress and duty status, and specifically prohibits telephone contact and personal visits by the employer with the physician. This applies to an agency's monitoring of medical evidence during the COP period as well as later in the life of the claim. This section is discussed further in the FECA Bulletin covering an employer's responsibility in returning employees to suitable work.

INCLUSION OF SUNDAY PREMIUM IN COP:

Section 10.216 outlines the calculation of COP. Generally, the various increments of pay are included in the pay rate for COP. However, several appropriation bills recently signed into law prohibited Federal agencies funded by those bills from paying Sunday premium pay to their

employees unless they actually performed work during the time period relevant to such pay. As OWCP cannot become involved in payroll functions among various agencies, section 10.216(a)(1) includes the phrase "except to the extent prohibited by law" to reflect these circumstances.

TERMINATION OF COP FOR DISCIPLINARY ACTION:

New section 10.222(b) allows an employer to terminate COP when a preliminary notice of a disciplinary action is issued before the injury, and becomes final or otherwise effective during the COP period. This revises previous section 10.201, which stated that the final written notice of termination must have been issued before the date of injury in order for the agency to terminate COP on that basis. The revision ensures that both the employee and the employer are in the same position as they would have been in but for the injury. As salary would not continue because of the disciplinary action, COP should not be paid.

Reference: 20 CFR 10.200 through 10.224, and 20 CFR 10.506

Purpose: To inform all claims staff of the revisions to the Regulations as they pertain to entitlement to COP

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Hearing Representatives, Fiscal Personnel, Technical Assistants and Systems Personnel

Action:

1. The claims examiner will decide claims for COP, which are challenged by either the agency or the claimant, according to the provisions of the revised Regulations outlined above. In most cases, Form CA-1050 can be used for formal denials of COP.

2. The District Offices should conduct training on this bulletin within 30 days of the date of the bulletin.

Disposition: This Bulletin should be retained 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 Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA BULLETIN NO. 99-07

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations - Subpart I - Information for Medical Providers

Background: On November 25, 1998, new final regulations for the FECA program were published. These regulations are effective January 4, 1999. Regulations previously found at 20 CFR 10.410 through 10.413 and 10.450 through 10.457 have been consolidated in Subpart I. Among the changes included in Subpart I are provisions for fee schedules for prescription medications, and inpatient hospital bills. In addition, National Drug Codes (NDCs) and Revenue Center Codes (RCCs) have been added to the list of codes which a provider must specify, the required form for hospitals has been changed from the UB-82 to the UB-92, and the required form for pharmacy bills is the Universal Claim Form.

The pharmacy fee schedule is based upon the average wholesale price (AWP), plus a dispensing fee equal to 20% of the AWP. The dispensing fee cannot be less than $2.50, nor greater than $15.00. A private vendor is the source of the AWP information. The data is updated monthly. The highest AWP over the prior two years is the price that will be used to calculate the allowable fee. If the amount charged for a prescription is more than the calculated fee (AWP plus dispensing fee), the calculated fee will be paid. If the amount charged is less than the calculated fee, the amount charged will be paid.

The inpatient hospital fee schedule is based on the prospective payment system (PPS) used by the Health Care Financing Administration's (HCFA's) Medicare program. Using the ICD-9 diagnosis and procedure codes that are found on the UB-92 billing form, along with other data, the hospitalization is assigned to a Diagnosis-Related Group (DRG), and is priced according to that DRG and other hospital-specific data. The HCFA PPS is based on the premise that similar medical conditions and surgeries require similar inpatient services and resources.

Certain inpatient hospital facilities (such as those that provide rehabilitation and psychiatric services) are not covered under the HCFA PPS. For those providers, OWCP will use HCFA-calculated cost to charge ratio (CCR) data to calculate the allowable fee.

Both the grouping (assigning the DRG) and pricing of inpatient hospital bills (except for non-PPS facilities, which will be calculated by National Office) will be performed by another Federal agency. The calculated allowable fee may be more or less than the billed amount. Unlike other FECA fee schedules, however, the allowable payment amount will nearly always be the calculated amount. Therefore, if the calculated fee is greater than the billed amount, the amount paid for an inpatient hospitalization may exceed the amount billed. This practice is consistent with the way Medicare processes their bills.

Notifications concerning the new fee schedules are being sent to all hospitals and pharmacies to whom payment was made during the last six months, as well as claimants who have received pharmacy reimbursements during the last year. Copies of those notices are attached (Attachments 1 - 3).

References: Federal Register, Volume 62, No. 246, published December 23, 1997; 20 CFR, Part 10, Subpart I, published November 25, 1998; FECA Bulletin 98-11; Federal (FECA) Procedure Manual Chapter 5-0206.

Purpose: To notify District Offices of changes in regulations regarding medical bills, and provide procedures for implementation of the pharmacy and inpatient hospital fee schedules.

Applicability: All staff.

Actions:

1. Bills for prescription drugs should continue to be keyed in accordance with FECA Bulletin 98-11.

2. Since pricing for prescription drugs is calculated using the number of units, accuracy of the units (quantity) is critical.

3. The allowable fees for each prescription will be calculated after the bills have been approved for payment and transmitted to the Central system. The allowable fee for a particular drug does not vary by location of the pharmacy.

4. By regulation, the only allowable bases for reconsideration of any fee schedule reductions are:

a. The procedure was incorrectly identified by original code;

b. The presence of a severe or concomitant condition made treatment especially difficult; or

c. The provider possessed unusual qualifications, beyond Board-certification in a specialty.

Requests for reconsideration must be made within 30 days of the payment, be in writing, and be accompanied by documentary evidence. Obvious errors may be corrected without going through the full appeals process as described in Federal (FECA) Procedure Manual Chapter 5-0206, but should be processed with an appeal code of 7.

The presence of a severe or concomitant medical condition which made treatment especially difficult will generally not be a relevant factor in pharmacy bills, nor will the qualifications of the pharmacy provider. Most frequently, the basis of an appeal would be:

a. Incorrect NDC code (appeal code 1 or 4);

b. Incorrect number of units (quantity)(appeal code 1 or 4); or

c. Incorrect data entry by OWCP (appeal code 7).

6. To process a request for reconsideration of a pharmacy fee schedule reduction:

a. Determine whether there is a valid basis for appeal;

b. If the basis for appeal is valid, calculate the allowable fee. The allowable fee per unit may be obtained by contacting OWCP's Branch of Medical Standards and Rehabilitation, telephone number (202) 693-0035. The per unit price should be multiplied by the quantity, and then to that amount add 20 percent of the product, no less than $2.50, no more than $15.00. The end result is rounded up to the nearest whole dollar. If the calculated fee amount is less than the amount already paid, no additional amount is payable, and the provider should be so informed at the appropriate signature level. If the calculated amount is greater than the amount already paid, a new payment should be entered on the system, with the calculated allowable amount as the bill total and the line charge amount, the prior paid amount as an ineligible amount, ineligible code C, bypass code 1, 2, or 3 as appropriate, and an appropriate appeal code.

c. If the basis for an appeal is not valid, the request should be denied at the appropriate signature level.

7. The allowable fee for inpatient hospital bills (with the exception of those keyed with a locator 4 code of 911) will be calculated after the bills have been keyed into special software and transmitted to the clearinghouse, and before the bills are loaded onto the Sequent systems in each district office. The allowable fee amount cannot be changed in bill resolution, but ineligible amounts and ineligible codes may be added.

8. New procedures for processing inpatient hospital bills are outlined in FECA Bulletin 99-21.

9. Generally, the only allowable basis for appeals of inpatient hospital bill payment amounts is coding error. The location and individual characteristics of the hospital are already factored into the price calculation. Severe or concomitant medical conditions are already part of the process for assigning the DRG, and the length of stay is factored into the pricing.

10. To process a reconsideration of an inpatient hospital fee reduction, take the following steps:

a. Determine whether the basis for the appeal is valid;

b. If the basis for the appeal is not valid, deny at the appropriate signature level;

c. If the basis for the appeal is valid, the bill should be rekeyed in the special inpatient hospital software, with the previously paid amount as a prior paid amount. The bill will then be forwarded for the usual processing (grouping and pricing). The presence of a prior paid amount will cause the bill to be loaded on the Sequent system as an indirect payment, which will cause edit 210 to suspend the bill. Upon reviewing the bill, the calculated DRG amount should be compared to the prior paid amount. If the prior paid amount is greater than the DRG amount, no additional payment is due. The bill should be internally denied, and the provider informed at the appropriate signature level. If the DRG amount is greater than the prior paid amount, an ineligible code of C should be added, and change the direct pay flag to Y (if direct pay) or override the edit 210 failure (if it is a claimant reimbursement with adequate proof of payment), enter an appropriate appeal code and bypass code, and recycle the bill.

11. The CA-91 Payment Notice is being revised to include general information concerning fee schedule appeals. A copy of the added text is shown as Attachment 4. Note that the reader is directed to contact the servicing district office for specific information on a fee reduction.

Training on these procedures should be completed as soon as possible, no later than January 15, 1999.

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)

Attachment 1

IMPORTANT NOTICE FOR HOSPITAL PROVIDERS

This notice applies to **inpatient hospital payments** made by the Office of Workers' Compensation Programs (OWCP) on behalf of injured **federal workers** covered under the Federal Employees' Compensation Act (FECA). The program provides coverage for work-related injuries and diseases for **civilian employees of the Federal government**. State and private sector employees are not covered by this Act.

FEE SCHEDULE FOR INPATIENT HOSPITAL BILLS - EFFECTIVE JANUARY 4, 1999

Charges for inpatient hospitalization will be subject to a fee schedule, as described in the Federal regulations at 20 C.F.R. 10.810, published on November 25, 1998.

The allowable amount will be calculated using formulae based on Medicare's Prospective Payment System (PPS) and Diagnosis-Related Groups (DRGs), with adjustments that reflect FECA-specific factors. These formulae always result in payments greater than Medicare's allowable per diem rate. Hospitals not subject to the PPS will be reimbursed according to formulae based on the cost-to-charge ratio.

Under the regulations governing the FECA, the program's payment constitutes the maximum payment. The hospital provider is not permitted to bill the injured employee for the difference between the OWCP allowable amount and the charged amount. Non-covered items, such as television and telephone charges, are always the responsibility of the patient. There is no deductible amount.

If the provider disagrees with a fee reduction, a reconsideration request may be made within 30 days of the payment. The request should be sent to the district office that has jurisdiction over the employee's claim.

BILLING INFORMATION

Claims for **inpatient hospital services** must be submitted on a completed Form UB-92. The UB-92 must contain the **provider's name**, **address**, **Tax Identification Number (TIN)**, and **Medicare Number**. In addition, the **injured worker's name** and **OWCP claim number**, the **type of bill** (Locator 4), the **period covered** by the statement (Locator 6), **covered days** (Locator 7), **birth date** (Locator 14), **sex** (Locator 15), **discharge status** (Locator 22), **total charges** (Locator 47), and the **discharge diagnoses and procedures** (if any) must be present on

the UB-92. Bills not submitted properly will be returned or denied.

Attachment 2

IMPORTANT NOTICE FOR PHARMACY PROVIDERS

This notice applies to **payments for pharmaceutical drugs** made by the Office of Workers' Compensation Programs (OWCP) on behalf of injured **federal workers** covered under the Federal Employees' Compensation Act (FECA). The program provides coverage for work-related injuries and diseases for **civilian employees of the Federal government**. State and private sector employees are not covered by this Act.

FEE SCHEDULE FOR PHARMACY BILLS - EFFECTIVE JANUARY 4, 1999

All charges for medications will be subject to a fee schedule, as described in the Federal regulations at 20 C.F.R. 10.809, published on November 25, 1998. The maximum allowable amount will be calculated based on the Average Wholesale Price (AWP) for the medication, plus a calculated dispensing fee, not to exceed $15.00. Dispensing fees should not be billed separately. Payment will be the lesser of the calculated fee or the billed amount. Charges that exceed the calculated fee will be reduced to the maximum allowable.

Under the regulations governing the FECA, the program's payment constitutes the maximum payment. The pharmacy provider is not permitted to bill the injured employee for the difference between the OWCP allowable amount and the charged amount. Non-covered items are always the responsibility of the patient. There is no co-pay amount.

If the provider disagrees with a fee reduction, a reconsideration request may be made within 30 days of the payment. The request should be sent to the district office that has jurisdiction over the employee's claim.

BILLING INFORMATION

All claims for prescription payments must be coded using **National Drug Codes (NDCs)**, and must also contain the **prescription number**, **refill number**, **decimal quantity**, and **date filled**. The pharmacy's **Tax Identification Number (TIN)**, full **name and address**, and the **name and OWCP case file number of the injured employee** must appear on the claim. Bills not submitted properly will be returned or denied.

Bills must be submitted either in electronic format through an intermediary (preferred), or on the paper Universal Claim Form. For information about electronic billing, contact William Cole at (202) 693-0041.

Attachment 3

IMPORTANT NOTICE CONCERNING PAYMENTS FOR MEDICATIONS

This notice applies to **payments for pharmaceutical drugs** made by the Office of Workers' Compensation Programs (OWCP) on behalf of injured **federal workers** covered under the Federal Employees' Compensation Act (FECA). The program provides coverage for work-related injuries and diseases for **civilian employees of the Federal government**. State and private sector employees are not covered by this Act.

FEE SCHEDULE FOR PHARMACY BILLS - EFFECTIVE JANUARY 4, 1999

All charges for medications will be subject to a fee schedule, as described in the Federal regulations at 20 C.F.R. 10.809, published on November 25, 1998. The maximum allowable amount will be calculated based on the Average Wholesale Price (AWP) for the medication, plus a calculated dispensing fee, not to exceed $15.00. Dispensing fees should not be billed separately. Payment will be the lesser of the calculated fee or the billed amount. Charges that exceed the calculated fee will be reduced to the maximum allowable.

Under the regulations governing the FECA, the program's payment constitutes the maximum payment. The pharmacy provider is not permitted to bill the injured employee for the difference between the OWCP allowable amount and the charged amount. If the injured employee has already paid for the medication in full, and reimbursement is being made to that employee, the reimbursement amount will not exceed the OWCP allowable amount. The employee should seek reimbursement for any remaining balance from the pharmacy provider. Non-covered items are always the responsibility of the patient. There is no co-pay amount.

If the provider (or a reimbursed employee) disagrees with a fee reduction, a reconsideration request may be made within 30 days of the payment. The request should be sent to the district office that has jurisdiction over the employee's claim.

BILLING INFORMATION

All claims for prescription payments must be coded using **National Drug Codes (NDCs)**, and must also contain the **prescription number**, **refill number**, **decimal quantity**, and **date filled**. The pharmacy's 9-digit Federal **Tax Identification Number (TIN)**, full **name and address**, and the **name and OWCP case file number of the injured employee** must appear on the claim. Bills not submitted properly will be returned or denied.

Bills must be submitted either in electronic format through an intermediary (preferred), or on the paper Universal Billing Form. For reimbursement to injured employees, a **Form CA-915**, claimant reimbursement form, is preferred. This form is used **in addition to** the Universal Billing Form.

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.

FECA Bulletin 99-07 Attachment 3

Attachment 4

FEE SCHEDULE APPEAL RIGHTS

The accompanying card shows charged amounts, reduction amounts, and paid amounts. Unless a different explanation is shown on the accompanying card, any reduction shown was made under the schedule of maximum allowable charges used by the Office of Workers' Compensation Programs (OWCP). The fee schedule applies to professional medical services, medicinal drugs, and inpatient hospital services, in accordance with 20 CFR 10.805 through 10.813. For additional information about the reduction, contact the servicing OWCP Office shown on the accompanying card.

A provider may not seek from the patient any additional charge or fee in excess of the charge allowed by OWCP. A provider who collects or attempts to collect any additional amount from the patient may be excluded from participating in the Federal Employees' Compensation Program and other Federal programs.

By regulation, the ONLY circumstances which will justify reevaluation of the amount paid are: (1) the service was incorrectly identified by code; or (2) the presence of a severe or concomitant medical condition made treatment especially difficult; or (3) the provider possesses unusual qualifications (beyond Board certification).

PROVIDER: If you disagree with the fee schedule reduction, you may take the following action within 30 days: (1) make written request for reconsideration of the fee determination, (2) identify the service in question, (3) attach documentary evidence relevant to one of the three circumstances described above, (4) attach a copy of this notice to your request, and (5) submit to the servicing OWCP Office, ATTENTION: FEE SCHEDULE APPEAL.

REIMBURSED PATIENT: If you paid the medical provider more than the OWCP reimbursement amount, take the following actions in the order presented: (1) show this notice to the medical provider and request a refund or credit of the difference; (2) ask the medical provider to submit an appeal as described above on your behalf; (3) request in writing that the servicing OWCP Office contact the medical provider concerning the amount you paid in excess of the fe schedule.

FECA Bulletin 99-07 Attachment 4

FECA BULLETIN NO. 99-08

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations--Privacy Act

Background: On October 22, 1998, the Department of Labor issued new regulations codifying changes in case law involving the Privacy Act. On January 4, 1999, the new Federal Employees' Compensation Act Regulations, further referencing the Privacy Act regulatory changes, became final.

The regulatory changes involving the Privacy Act primarily serve to formalize handling of Privacy Act requests. There is a major change, however, in the delineation of which specific situations may require exemption of records from disclosure.

Reference: 29 CFR Parts 70a and 71; 20 CFR 10.10 through 10.13

Purpose: To inform OWCP staff and employing agencies of Privacy Act compliance requirements.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel, and Hearing Representatives

Action:

1. All records in OWCP's files and all copies of these records in the possession of the employer are considered to be OWCP records, covered by the DOL/GOVT-1 system of records. This means that although employing agencies may establish procedures for access to the records that they maintain, their decisions to grant/deny access must comply with Department of Labor rules and regulations.

2. This said, only OWCP may respond to requests for correction or amendment to any OWCP record. Employing agencies must forward such requests to OWCP without acting upon them.

If release of records is approved, the request may be read to consent to copying fees up to

$25.00. The requester must be consulted before higher fees will be assessed. Fees will apply as follows:

The first copy of the requested information must be provided at no cost. Any additional/later copy should be provided at a cost of $.15 per page, but the first 100 pages will be free of charge.

OWCP may require payment in advance of fees over $250. If such a fee is anticipated, a letter should be sent to the requester, noting the amount of the fee and advising that the requester may contact a designated OWCP staff person to attempt to reformulate the request to meet his or her needs at a reduced cost.

4. Any decision on a Privacy Act request must be given in writing, whether an approval or denial. An approval should include discussion of any fees, if over $25.00, and should, whenever possible, also include the copy of the records requested. Should copying be delayed, an interim response notifying the requester of the approval, the length of the anticipated delay, and a reason for the delay, should be provided. All decisions should be issued over the signature of the designated Privacy Act officer. At the District Office level, this is the District Director or his or her designee.

5. A Privacy Act request may be denied only if the information requested is excepted from release for one of the following reasons:

a. Release of the records would allow the subject of an investigation to know he or she was the subject of an investigation, to determine the nature of the investigation, or to determine the identity of witnesses/informants, or

b. Release of the records would inform the subject of an investigation of other actual/potential violations of law that have been uncovered via investigation.

6. If access to a certain record (or records) is being denied, the denial must be formal, in writing, over the signature of the District Director, and include a statement of the reasons for denial, including the specific exemption, and a statement that appeal is possible. The appeal statement should indicate that appeal must be made within 90 days of the receipt of the denial notice, and that it must be made to the Solicitor of Labor. A sample letter for this purpose is attached.

7. If OWCP is unable to locate a record for which a Privacy Act request has been made, OWCP should notify the requester of this in writing, with the same 90-day appeal rights as outlined in item 6 above.

<u>Disposition:</u> Retain until incorporated into 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)

Attachment: Sample Letter

DATE

File #

Dear NAME:

We have received your recent request for release of (LIST INFORMATION HERE). After full consideration of your request, it has been determined that we are unable to release this information. Our inability to release the information is because (LIST EXEMPTION HERE).

You have the right to appeal this decision. Your appeal must be dated within 90 days of your receipt of this notice. Should you wish to appeal, please state your reasons in writing to:

Solicitor of Labor
U.S. Department of Labor
Room S-4325
200 Constitution Avenue, NW
Washington, DC 20210-0002

Note that both your letter and envelope should be marked "Privacy Act Appeal." If they are not so marked, they will not be counted by the Solicitor of Labor as received until identified as a Privacy Act appeal and forwarded to the appropriate office for handling.

Sincerely,

DISTRICT DIRECTOR

FECA BULLETIN NO. 99-09

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations: Attendant's Allowance

Background: New section 10.314 of the regulations allows payment for the services of an attendant to be made only directly to the provider of the service, up to the maximum of $1500 per month allowed by 5 U.S.C. 8111. There will be no further payments made directly to claimants for the services of an attendant for any new claims for such services.

Where direct payments were being made to the claimant to cover the services of an attendant prior to January 4, 1999, such payments will continue until such time as the services of an attendant are no longer necessary.

In order for claims to be handled in a uniform manner in each district office, any claim for attendant services that is postmarked prior to January 4, 1999, the effective date of the new regulations, will be considered under the old regulations. Payments will be made directly to the claimant until the need for the attendant ceases. Once the services of the attendant are terminated, any new claims for attendant services will be considered under the new regulations.

OWCP will pay for attendant services as a medical service under 5 U.S.C. 8103, rather than under 5 U.S.C. 8111(a). This will allow for greater fiscal control, as bills submitted directly to OWCP will be subject to the fee schedule, and will be reviewed to ensure that charges are correct. It will also allow for quality review, ensuring that necessary services are being provided by a home health aide, licensed practical nurse or similarly trained individual.

The criteria for determining whether the services of an attendant are required have not changed. However, the method of payment has changed, and any references in the Procedure Manual to payment of an attendant allowance to the claimant is superceded by this bulletin.

The system updates required to support the payment of an attendant allowance as a medical expense are under development. Additional procedures in this regard will be issued when they are finalized. For now, use provider type code C when paying for attendant care.

References: 20 CFR 10.314

Purpose: To inform all claims, rehabilitation, and fiscal staff of the revisions to the Regulations as they pertain to the payment for the services of an attendant.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Rehabilitation Specialists, Technical Assistants, and District Medical Advisors

Action:

1. Upon receipt of a request for payment of the services of an attendant, release Form Letter CA-1090 to the claimant's physician. Form Letter CA-1086 is no longer relevant as that primarily addresses the claimant's method of paying the attendant.

2. Upon receipt of the reply from the claimant's physician, consider entitlement to an attendant allowance according to the criteria found in the Procedure Manual in Chapter 2-812.

3. In those cases where the services of an attendant are approved, the claims examiner will prepare a memorandum for the file which indicates the reasons for approving the attendant allowance, and stating the period for which it is approved. A claims examiner may approve the services of an attendant up to one year at a time if the medical evidence supports a long-term need.

4. Enter a note in the automated system stating that an attendant allowance is approved, the period for which it is approved, and that it is limited to the amount of $1500 per month. Advise the claimant of the approval; that the services should be provided by a home health aide, licensed practical nurse, or similarly trained individual; that the amount is limited to $1500 per month; and that the provider should submit their bill for services directly to OWCP using Form HCFA 1500 or OWCP 1500 as directed in 20 CFR 10.801.

5. For cases where an attendant allowance is currently being paid directly to a claimant, continue such payments under the old procedures. After the need for the attendant services ends, consider any new claims for an attendant allowance under the new regulations.

6. Process any pending claims for an attendant allowance, which are postmarked before January 4, 1999 under the old procedures.

7. Process all approved charges for the services of an attendant for payment directly to the provider of the services, up to a maximum of $1500 per month, and subject to the fee schedule. Use provider type C when paying for attendant care. At the present time, there is no indicator in the system to limit the payments for attendant services to $1500 per month. This must be monitored as the bills are paid.

8. If charges over the allowed amount are received, return them to the provider with an explanation that the charges for attendant services exceed the allowed monthly limit.
9. The District Offices should conduct training on this bulletin within 30 days of the date that this bulletin is received.

Disposition: This Bulletin should be retained 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 Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Hearing Representatives, Rehabilitation Specialists, and Staff Nurses)

FECA BULLETIN NO. 99-10

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations--Continuing Benefits

Background: The new regulations governing claims under the FECA contain a subpart headed "Continuing Benefits" that codifies several OWCP procedures and marks some changes in those procedures.

For the first time, the regulations at 10.502 explain how OWCP weighs medical evidence in reaching final decisions. This section codifies the long-held practice of weighing medical reports, including those of a second opinion and a treating physician, to determine whether a referee examination is warranted or whether a decision on ongoing compensation entitlement may be made without further medical opinion.

Section 10.505 clarifies that OPM, not OWCP, is responsible for ensuring that employing agencies make all reasonable efforts to re-employ injured workers who have fully recovered after more than one year.

Section 10.506 contains a change from the previous regulations to indicate that while employers may contact employees' treating physicians for periodic medical progress reports, this should be done only in writing. All such correspondence must also be forwarded to OWCP for inclusion in the file. Employers are also given permission to contact injured workers directly at reasonable intervals to obtain periodic medical reports addressing return to work.

OWCP's handling of reduction in force (RIF) situations is outlined in Section 10.509. This section indicates that elimination of a light-duty position via RIF or downsizing is not prima facie evidence of recurrence. Instead, OWCP must determine the injured worker's wage earning capacity based on his or her actual earnings in the light-duty job if such earnings fairly and reasonably represent his or her wage-earning capacity and no wage earning capacity decision has previously been issued. This section also indicates that, in order for an actual earnings wage earning capacity rating to be issued, the position must formally be classified by occupational series and grade level and include a written position description. Otherwise, OWCP assumes that the injured worker was employed in a non-competitive position not representative of his or

her wage-earning capacity.

Section 10.516 codifies the decision of the Employees' Compensation Appeals Board in the case of *Maggie Moore*. It is now part of the regulations that, in order to terminate compensation based on refusal of a suitable position, OWCP must first give a 30-day notice that the job was found suitable and request reasons for refusal and then, if a response is received and found to be invalid, the injured worker must be given an additional 15 days to accept the position without penalty. If an injured worker does not respond to the 30 day letter, no further action is required prior to termination of benefits, as has been OWCP procedure.

On the same topic, section 10.517 notes that although compensation is terminated under 5 U.S.C. 8105, 8106 and 8107 in the case of refusal of suitable employment, entitlement to medical benefits continues.

Section 10.518 affords OWCP nurse intervention services the same status as vocational rehabilitation services under 5 U.S.C. 8104. This also allows the same penalty provisions for non-compliance with vocational rehabilitation services to apply to non-compliance with nurse intervention. The section, in part (b), also formally makes Functional Capacity Evaluations (FCE's) part of vocational rehabilitation services, in effect giving the current Occupational Rehabilitation Program (ORP) procedures the force of regulation.

Section 10.526 provides that individuals receiving compensation for partial or total disability are required to report volunteer activity when reporting all work activity. This will be incorporated into the new version of the CA-1032 effective January 4, 1999.

Section 10.527 provides notice that OWCP may use computer matching with various Federal and state agencies to verify wage information.
<u>Reference:</u> 20 CFR 10.500 through 10 CFR 10.541

<u>Purpose:</u> To inform OWCP staff of significant regulatory changes regarding continuing benefits.

<u>Applicability:</u> Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel, and Hearing Representatives

<u>Action:</u>

1. Claims Examiners should continue basing decisions on the weight of medical evidence, only utilizing referee examinations when the weight of the medical evidence of record is truly equal, and a conflict exists therein.

2. In cases where a recurrence is claimed due to the removal of light duty, determine whether the removal was due to RIF or downsizing. If not, as has been the current practice, the claimant

has established a recurrence of disability.

If the recurrence claim is due to RIF or downsizing and an actual earnings LWEC decision is in place, the claims examiner must determine whether the position utilized for that LWEC determination was classified as outlined above. If the LWEC determination was in fact based on a classified position the LWEC remains in force and the recurrence should be denied. If not, the claimant's entitlement to compensation is based upon the compensable recurrence.

If no LWEC decision is in place, the claims examiner must determine whether the light duty position the claimant was performing is appropriate for an actual earnings LWEC. To be appropriate, the position must have been classified as indicated above. If this is the case, an actual earnings LWEC should be issued. As in the case of previously issued LWEC decisions, if the position the claimant worked until the RIF is not classified, he or she is entitled to compensation due to the claimed recurrence.

3. In cases where an injured worker has refused a job offer deemed suitable, be certain to allow the full due process now required by regulation. This means that a 30-day response period must be provided initially, followed by a 15-day period to accept the job if the employee provides reasons for his or her refusal.

Note that injured workers are now required to undergo nurse intervention services, or face sanctions for non-compliance as outlined at 20 CFR 10.519. Refusal to participate at the nurse intervention stage would most generally be construed as early-stage refusal. Therefore, non-compliance with nurse intervention services would result in the assumption that participation would have resulted in employment with no loss of wage-earning capacity, and OWCP will reduce compensation to zero until the employee acts in good faith to comply with nurse intervention services. A new letter is being added to Forms Correspondence to outline the penalties for non-compliance with nurse intervention. The number of this letter will be made available separately. A copy of the letter is attached, however, so that claims examiners may begin to use it effective January 4, 1999 in appropriate situations.

5. The CA-1657, applying to early non-cooperation with vocational rehabilitation efforts, has been altered to reflect the new regulatory sections from which the authority for sanctions stem. This letter will also be made available via forms correspondence.

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)

Attachment: Sample Letter--Cooperation with nurse services

File #

DATE

ADDRESS
ADDRESS
ADDRESS

Dear :

A Registered Nurse has attempted to contact you in relation to your claim under the Federal Employees' Compensation Act. The main purpose of this contact is to assist you in returning to gainful employment. Nurse services include (but are not limited to) important steps toward reemployment such as work evaluations, coordination of medical efforts, and facilitation of efforts between you and your employer. Your refusal without good cause to meet with the nurse and assist in these efforts may be seen as refusal to undergo vocational rehabilitation.

The following specific circumstances support a finding that you are refusing to cooperate with the nurse intervention, and by association, the vocational rehabilitation efforts of the Office of Workers' Compensation Programs (OWCP):

FREEFLOW TEXT

PROVISIONS OF THE LAW AND REGULATIONS

The Federal Employees' Compensation Act (FECA) at Section 5 U.S.C. 8113(b), states that a claimant must undergo vocational rehabilitation when OWCP so directs, unless there is a good reason not to do so. Therefore, if you do not undergo vocational rehabilitation as directed, including nurse services, and OWCP finds that your wage-earning capacity would likely have increased a great deal, OWCP may reduce your compensation. The amount of the reduction will be based on what you would probably have earned had you undergone nurse intervention and/or vocational rehabilitation.

Also, the Code of Federal Regulations at 20 CFR 10.518 and 20 CFR 10.519 states that an injured worker must take the steps described above to prepare for reemployment, unless there is a good reason not to do so. Therefore, unless you produce evidence to the contrary, OWCP will assume that nurse intervention would have resulted in return to work with no loss of

wage-earning capacity, and will reduce your compensation accordingly--that is, to zero. This reduction will continue until you comply in good faith with OWCP's directions concerning nursing services. If you do comply, compensation will then be paid to you, except for the period when you did not comply.

If your compensation is reduced to zero under the provisions of Section 20 CFR 10.518 and 10.519, any deductions which OWCP is making for health benefits (HB) and/or optional life insurance (OLI) premiums will cease and any HB/OLI coverage will be terminated. If you later comply with OWCP's instructions, OWCP will reinstate HB/OLI coverage and deduct any past due premiums from continuing compensation.

REQUIREMENTS FOR RESPONSE

You are hereby directed to contact me within 30 days from the date of this letter to make a good faith effort to participate in the Registered Nurse's efforts to return you to gainful employment.

If you believe you have good reason for not participating in this effort, so advise this office within 30 days from the date of this letter. Give your reasons and submit any evidence to support your position. Also, if you believe that nursing services would not reduce your wage-earning capacity to zero, submit evidence to support your position within 30 days.

If you do not comply with the instructions contained in this letter within 30 days, we will end the rehabilitation effort and reduce your compensation under the provisions of Section 8113(b) and Section 20 CFR 10.519 as described above.

If you have any questions, please contact this office using the address or telephone number shown on the previous page.

Sincerely,

CLAIMS EXAMINER

FECA BULLETIN NO. 99-11

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations: Compensation and Related Benefits

Background: Subpart E of the Regulations includes sections 10.400 through 10.441, and addresses the payment of compensation and overpayments. This subpart includes several revisions which formalize current practice. There are no new procedures related to these revisions.

COMPENSATION PAYMENTS

Section 10.400, in defining total disability, now includes a statement that OWCP expects that most employees will eventually return to work.

Section 10.404 formalizes the fact that OWCP uses the AMA Guides to the Evaluation of Permanent Impairment as its frame of reference for calculating schedule awards.

In sections 10.406 and 10.411, which concern maximum and minimum rates of compensation, the word "basic" has been prefixed to "monthly pay" to make clear that locality adjustments are not included in these determinations. Statements have also been added to recognize that compensation paid due to an assault which occurred during an attempted or actual assassination of a federal official in the performance of duty is exempted from the maximum rates.

Section 10.417, provides that OWCP may, at least twice each year, request reports to verify student status or the inability of a child over 18 to support himself or herself. This is consistent with most school enrollment schedules, and reminds recipients that a child over 18, not enrolled in school for a semester, is not eligible for survivor benefits for that semester.

New Section 10.421(c) formalizes the fact that a claimant cannot receive benefits for total disability and severance or separation pay for the same period. A schedule award or an LWEC can be paid concurrently with separation or severance pay.

New section 10.421(d) includes changes made to the FECA when the Federal Employees'

Retirement System (FERS) was instituted. The relevant procedures are outlined in FECA Bulletin 97-9.

Section 10.423 reflects changes to various federal laws, making it clear that compensation payments can be garnished to collect overdue alimony and child support payments, upon presentation of a State agency or court order.

Section 10.424 condenses the material regarding representative payees into one paragraph, as the detailed guidance previously given was largely procedural rather than regulatory.

LEAVE BUY-BACK

The only reference in the revised regulations to the leave buy-back process is found in section 10.425. This section states only that an employee may claim compensation for restorable leave in accordance with the rules of the employing agency. Leave buy-back is not authorized or required by the FECA, and is not controlled by OWCP. It is controlled by each employing agency. The only relationship between those rules and the FECA is the general prohibition against paying wage-loss benefits for a period where leave was used. The previous regulatory reference to the repurchase of leave inadvertently gave the impression that OWCP controlled leave buy-back.

OVERPAYMENTS

The regulations concerning overpayments have been extensively rewritten to make it clear that a FECA beneficiary is obligated to be aware of the period for which benefits are paid and the manner in which overpayments are declared, contested and collected. The revised overpayment regulations are in sections 10.430 through 10.441.

New section 10.430 describes the method by which OWCP notifies recipients of payments. In the absence of evidence to the contrary, it will be presumed that the beneficiary received the notice. Once put on notice of a payment and the amount, the recipient is responsible for notifying OWCP of any discrepancies.

Sections 10.436 and 10.437 discuss the two circumstances under which an overpayment can be waived, and makes it clear that the equity and good conscience test for waiver applies to all individuals who are without fault regardless of whether they are present or former beneficiaries under the Act. This restores the statutory distinction between the application of the two tests for waiver, which was unintentionally removed as a result of the 1987 revision of the regulations.

Section 10.441 clarifies the fact that an overpayment is a debt subject to the Debt Collection Act of 1982, and if not paid, OWCP will recover the debt by any available means.

Reference: 20 CFR 10.400 through 10.441, FECA Bulletin 97-9

Purpose: To inform all claims staff of the revisions to the Regulations as they pertain to the payment of compensation and overpayments

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Hearing Representatives, Fiscal Personnel, Technical Assistants and Systems Personnel

Action:

The District Offices should conduct training on this bulletin within 30 days of the date that this bulletin is received.

Disposition: This Bulletin should be retained 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 Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses

FECA BULLETIN NO. 99-12

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations - Reconsiderations and Reviews by the Director; Reviews by the Employees' Compensation Appeals Board

Background: The changes to the regulations included additional information regarding the reconsideration process and reviews by the Director on his or her own motion under § 8128 of the FECA. The major substantive change implemented in this area concerns the merit review on the Director's own motion. The new regulations state at § 10.610 that a decision to review on this basis is not subject to a request or petition and that none shall be entertained. That is, the Office has full discretionary authority in these matters, and the claimant cannot request review on the Director's own motion. In § 10.610(a) the regulations point out that a decision to review or not to review on the Director's own motion is also not subject to review by the ECAB, nor can it be the subject of a reconsideration or a hearing request. On the other hand, any decision which results from a review on the Director's own motion can be subject to whichever of the three avenues of appeal the claimant selects, including reconsideration, hearing or review by the Employees' Compensation Appeals Board.

Other changes include an extension of the period (from 15 to 20 days) for comment by the employer on the claimant's application for reconsideration and any additional evidence the claimant submits in support of his or her application. This is balanced by allowing the claimant 20 days (instead of 15) to respond to any comments on his or her application made by the employer.

The only other substantive change is the fact that the new regulations on the reconsideration process and review by the Director are explained in six sections [§10.605 through §10.610] of Subpart G - Appeals Process, making the discussion more thorough. Comparatively, the previous regulations included these topics in one section [§10.138] of Subpart B - Notice of Injury and Claim for Compensation, Administrative Procedures. The six sections provide much greater detail concerning the definition of reconsideration by the Office [§10.605], the procedure for requesting a reconsideration [§10.606] along with the time limits for doing so [§10.607]. These sections go on to explain how the Office evaluates the evidence submitted by the claimant to determine whether it warrants a merit review [§10.608], and if so, whether, upon review, the evidence or arguments presented are sufficient to warrant modification of the previous merit

decision [§10.609]. The last of the six sections [§10.610] addresses the process of review on the Director's own motion and is discussed above.

With regard to requests for review by the Employees' Compensation Appeals Board, the changes include a more in-depth discussion of appeals to the Board. Specifically, at §10.625 the new regulations address the types of decisions which may be appealed to the Board. Also in Subpart G at §10.626, the new regulations specify which entity has jurisdiction (the Board or the district office) over the cases while they are on appeal based on the issue(s) being addressed by ECAB in its review.

Reference: 20 CFR Part 10, Subpart G, Sections 10.605 through 10.610; Sections 10.625 and 10.626; Federal (FECA) Procedure Manual, Chapters 2-1600 (paragraphs 2.c. and 2.d.), 2-1602 and 2-1603; FECA Circular 99-04

Purpose: To focus on the part of the new regulations which addresses the reconsideration process and reviews on the Director's motion, and to point out that the deadline has been extended for the employing agency to submit comments on the application for review, and for the claimant to respond to any comments submitted.

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

Action:

1. The training on the new regulations should include emphasis on the discussion in §10.610 which addresses reviews on the Director's own motion. Most importantly, the CEs should be clear on the point that pursuant to this section a claimant may not request review on the Director's own motion.

2. The district offices should also ensure that any pre-formatted letters used for requesting comments or responses to comments are amended to reflect the changes from 15 to 20 days for submission of comments and responses.

3. Attachments 1, 2, and 3 correspond to Exhibits 2, 3, and 4 of Chapter 2-1602 and are replacements until such time as the FECA Procedure Manual is updated to incorporate these changes. They contain the corrected address for the Employees' Compensation Appeals Board and a corrected reference to the new regulations at 20 CFR 10.607(a) pertaining to timely requests for reconsideration.

4. Training for all claims personnel which focuses on Subpart G-Appeals Process (changes in the appeals process pursuant to the new regulations) should be accomplished within 30 days of receipt of this FECA Bulletin.

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. 1--Folioviews Groups A and D
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

Attachment 1

SAMPLE LETTER DENYING AN UNTIMELY
REQUEST FOR RECONSIDERATION

Dear CLAIMANT NAME:

This is in reference to your letter dated DATE OF LETTER requesting reconsideration of our decision dated DATE OF LAST MERIT DECISION. Your letter was postmarked [OR dated] on DATE.

As provided by 20 CFR 10.607(a), we will not review a decision unless the request to do so is filed within one year of the date of that decision. Accordingly, your request for reconsideration is hereby denied because it was not postmarked [OR dated] within the one-year time limit.

We have evaluated the evidence you submitted in support of your request to see if it constitutes clear evidence of error [as described in § 10.607(b)] in OWCP's original decision. Such error would require the OWCP to reopen the case even though your request for reconsideration is untimely. However, an evaluation of the evidence you submitted does not show clear evidence of error on the part of OWCP.

If you disagree with this decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision. This is your only right of appeal. No new evidence may be submitted to the Board. Request for review by the Appeals Board should be made within 90 days from the date of this decision and should be addressed to Employees' Compensation Appeals Board, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2609, Washington, D.C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

Sincerely,

SENIOR CLAIMS EXAMINER

Attachment 2

SAMPLE LETTER DENYING AN APPLICATION WHICH IS PRIMA FACIE INSUFFICIENT TO WARRANT REVIEW OF THE CASE

Dear CLAIMANT NAME:

We have reviewed your letter of DATE OF LETTER requesting reconsideration of our decision dated DATE OF DECISION.

Please refer to the information which accompanied the original decision. To require the Office to reopen your case, you must clearly identify the grounds upon which reconsideration is being requested. In addition, you must either submit relevant evidence not previously considered, or present legal arguments not previously considered.

Because your letter did not include new and relevant evidence or new legal arguments, it is insufficient to warrant a review of our prior decision at this time. Any future request for reconsideration must be made within one year from the original decision and must be accompanied by statements or evidence as described above.

If you disagree with this specific decision, namely, our denial to review our prior decision, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision. This is your only right of appeal. No new evidence may be submitted to the Appeals Board.

A request for review by the Appeals Board should be made within 90 days from the date of this decision. It should be addressed to Employees' Compensation Appeals Board, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2609, Washington. D.C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

Sincerely,

SENIOR CLAIMS EXAMINER

Attachment 3

SAMPLE NOTICE OF THE ONE-YEAR TIME LIMITATION
FOR REQUESTING RECONSIDERATION

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with this decision denying reconsideration of your case, you may request review by the Employees' Compensation Appeals Board. No new evidence may be submitted to the Board. Request for review by the Appeals Board should be made within 90 days from the date of this decision and should be addressed to Employees' Compensation Appeals Board, U.S. Department of Labor, 200 Constitution Avenue, N.W., Room N-2609, Washington, D.C. 20210. For good cause shown, the Appeals Board may waive the failure to file within 90 days if application is made within one year from the date of the decision being appealed.

NOTICE

Section 10.607(a) of Title 20 of the Code of Federal Regulations, which concerns the reconsideration of a decision by the Office of Workers' Compensation Programs (OWCP), provides that OWCP will not review a decision denying or terminating a benefit unless the claimant's request for review is filed within one year of that decision. This provision of the earlier regulations became effective June 1, 1987. Therefore, even if the decision in your case was issued prior to June 1, 1987 and included the right to reconsideration, without specifying a time limit, a request for reconsideration of that decision will be denied if it is not made within one year from the date of this notice.

FECA BULLETIN NO. 99-13

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations: Medical and Related Benefits

Background: Subpart D of the Regulations, which includes sections 10.300 through 10.337, has been substantially revised. This bulletin discusses the revisions to subpart D.

FORMALIZING CURRENT PRACTICE

Most of the additions merely formalize current practice. Those are as follows.

In 10.300, the statement that the employer need not issue a Form CA-16 more than one week after the occurrence of the claimed injury has been added. The purpose of the issuance of this form is to ensure that necessary immediate medical care is not hindered through uncertainty by the provider of who is responsible for payment.

Sections 10.301 and 10.316 address physician referrals. 10.301 now states that the physician designated on the CA-16 may refer a claimant for additional treatment and OWCP will pay the associated costs. 10.316 clarifies that an employee need not consult OWCP for approval when the physician initially selected refers the employee to a specialist appropriate to the nature of the injury.

Section 10.312 concerns the services of clinical psychologists. It specifies that a clinical psychologist may treat a FECA claimant within the scope of practice allowed by applicable state law.

Section 10.313 reflects OWCP policy as stated in internal procedures that preventive treatment may only be authorized where a verifiable work-related injury is present.

Sections 10.320 and 10.321 address medical referrals initiated by OWCP. A statement has been added to make clear that the claimant is not entitled to have anyone attend such examinations (except for a physician of his or her choice, at a second opinion examination) unless OWCP finds that exceptional circumstances, such as the need for having an interpreter for a hearing-impaired claimant, exist. A statement has also been added that a case file may be sent for second opinion or referee review where an actual examination is not needed, or where the employee is deceased.

Section 10.330 now includes "extent of disability" and "prognosis" in the list of items that a medical report from the attending physician should include.

To reduce confusion, a statement that the use of form reports is not required has been added to section 10.331. This section also makes it clear that medical reports must have signatures. OWCP recognizes that many medical providers use signature stamps, but reserves the right to request an original signature on any medical report.

Section 10.324 formalizes the long-standing position of OWCP that any authority that an employing agency has to require an employee to undergo a medical examination does not come from the FECA, and nothing in the FECA or the regulations affects such authority. In addition, no agency-required medical examination or related activity shall interfere with the employee's initial choice of physician or the issuance of Form CA-16.

NEW PROCEDURES

A few revisions represent new procedure. There are two significant new procedures added to this subpart. One is in section 10.314, which changes the way attendant allowances are paid. The revised procedures for attendant allowances are the subject of FECA Bulletin 99-09, and will not be repeated here.

The other significant revision is to section 10.337, regarding the reimbursement of claimants for medical expenses. When a claimant pays for medical services directly, and then applies to OWCP for reimbursement, the amount payable by OWCP will be limited by the fee schedule. The claimant may be only partially reimbursed because the amount paid to the provider exceeds the maximum allowable charge.

It is then the claimant's responsibility to ask the provider to refund to the claimant, or credit to the claimant's account, the amount he or she paid which exceeds the maximum allowable charge. If the provider does not refund or credit the excess amount paid, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may reimburse the employee the difference after reviewing the facts of the case.

A notice, which will accompany all bill payments, is currently under development. The notice will advise providers and claimants of the provisions of the fee schedule, and the prohibition of a provider seeking additional charges from the patient. It will also provide instructions to the provider and the claimant in this regard.

In addition to the two significant revisions noted above, there are a few less significant revisions that represent new procedures. They are as follows.

Section 10.303 instructs employers not to use a Form CA-16 to authorize medical testing for an employee who has merely been exposed to a workplace hazard, unless the employee has sustained an identifiable injury or medial condition as a result of that exposure.

Section 10.310 includes new references to cost effectiveness with respect to appliances and supplies, and to generic equivalents of prescribed medications. It states that OWCP will not approve an elaborate appliance or service where a more basic one is suitable. This section also gives OWCP the authority to require the use of generic medications where they are available. District office personnel are not to make determinations regarding generic medications at this time. When guidelines are developed by the National Office, you will be advised.

A statement has been added to section 10.311, which addresses the services of chiropractors, that OWCP will not necessarily require the x-ray or the report of the x-ray before adjudication. It may be requested if there is any indication in the factual or medical evidence of file that there may not be a subluxation present.

A sentence has been added to section 10.323 providing that the actions of an employee's representative will be considered the actions of the employee for the purposes of determining whether a claimant refused to submit to or in any way obstructed an examination required by OWCP.

Reference: 20 CFR 10.300 through 10.337

Purpose: To inform all claims staff of the revisions to the Regulations as they pertain to medical and related benefits

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Hearing Representatives, Fiscal Personnel, Technical Assistants and Systems Personnel

Action:

1. The claims examiner will evaluate claims for medical and related benefits according to the provisions of the new regulations outlined above.

2. When OWCP receives documentation from a claimant that they requested refund or credit from the provider, and the provider failed to refund or credit the claimant's account, the claims examiner should review the facts of the case and make any reasonable reimbursement to the employee. The CE should also advise the claimant that they may not be reimbursed the excess amount in the future. Once such a payment is made, and the employee is aware of the monetary costs of continuing to seek treatment with such a provider, the claims examiner should consider not reimbursing the employee for any subsequent excess charges.

3. In claims where a medical report is received from a chiropractor indicating that x-rays demonstrate a subluxation, other factual and medical evidence in file should be carefully evaluated for consistency with this diagnosis. Where the evidence is consistent with the diagnosis of subluxation, that condition should be accepted, and appropriate benefits paid, without requiring the submission of the x-ray or the report of x-ray upon which the diagnosis is based. Where either factual or medical evidence of file suggests that the diagnosis of subluxation may not be accurate, the claims examiner should request that the x-ray or the report of the x-ray upon which the diagnosis was based be submitted for review prior to accepting this diagnosis.

4. The District Offices should conduct training on this bulletin within 30 days of the date that this bulletin is received.

Disposition: This Bulletin should be retained 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 Advisors, Fiscal Personnel, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses

FECA BULLETIN NO. 99-14

Issue Date: January 4, 1999

Expiration Date: Janaury 3, 2000

Subject: New Regulations--Representative Fees

Background: On January 4, 1999, the new Federal Employees' Compensation Act Regulations became final. Subpart H of these regulations contains a discussion concerning who may serve as a representative and how fees will be paid.

The regulations now specify that federal employees may not serve as representatives except in instances where the person they are representing is an immediate family member, or where the representative is an officially sanctioned union official charging no fee or gratuity for his or her services.

Additionally, attorney fee applications have been streamlined. Any fee application accompanied by a signed statement from the claimant agreeing to the fee will be approved. Only where a claimant disagrees with the amount of the fee will further action be taken.

Reference: 20 CFR 10.700 through 10.703

Purpose: To inform OWCP staff of new regulations regarding representatives.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel, and Hearing Representatives

Action:

1. All claimants and the representatives they retain will now be advised via newly revised form CA-0143 (Attachment 1) of procedures relating to fee applications.

2. Claims Examiners must now be alert for any federal employee functioning as a representative. Should any documentation be received identifying a representative as a federal employee, the claims examiner should draft correspondence inquiring as to the nature of the relationship between the claimant and representative, and whether remuneration is involved for the representative’s services. Attachment 2 is a sample letter for this purpose.

3. In cases where a representative has submitted an itemized billing and the fees have been agreed to, the fee should be approved. Note that to be approvable, the fee application must contain:

a. the representative's hourly rate
b. the number of hours worked
c. the specific work performed
d. a total of charges exclusive of administrative costs
e. concurrence from the claimant

While this is substantially similar to the requirements prior to the regulatory change effective January 4, 1999, OWCP staff are no longer required to evaluate services provided or the hourly rate at which they were charged in order to determine the propriety of the charges where a claimant has concurred with them. Instead, the fees should be approved, and this should be noted via use of form CA-1066, which has been newly revised to reflect these regulatory changes. A copy of this letter is at Attachment 3 for your reference. Note that this is a formal decision, and must be completed at an appropriate signature level as per current procedure and within current limits (up to $10,000 may be issued by claims examiners or senior claims examiners, over $10,000 must be issued by the District Director).

4. Should an application be submitted which does not contain any item cited in action item 3(a) through (e), above, it will be returned as incomplete without comment. Attachment 4 is a sample letter for this purpose.

5. If a representative submits a fee request with which his or her client does not concur, OWCP must review the request and issue a decision either approving or denying it. In order to reach this decision, you must provide a copy of the request to the claimant and ask him or her to provide any additional information in support of his or her objection to the fee within 15 days. After those 15 days, OWCP must evaluate the fee request to determine whether the amount of the fee is substantially in excess of the value of services received. To do this, you must consider:

a. the usefulness of the representative's services
b. the nature and complexity of the claim
c. the actual time spent by the representative
d. customary local charges for similar services.

After fully considering these items, a formal decision must be issued outlining the fee approved and the reasons for denial of any portion of the fee as requested. This decision should be issued at the Senior Claims Examiner level.

Training on these items should be conducted within 30 days of receipt of this bulletin.

Disposition: Retain until incorporated into 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)

Attachment 1: Form CA-0143 and Form CA-1055

File Number:
Date of Injury:
Employee:

Dear :

This will acknowledge the receipt of a statement from the above-named employee designating you to pursue his/her case before the Office of Workers' Compensation Programs (OWCP).

The OWCP's procedures relative to representatives' fee applications, copy enclosed are designed to reduce or eliminate the timelag between case approval/payment and the decision in respect to the fee request. If a representative submits a fee application in accordance with the enclosed instructions, it will be acted upon at the same time the case is adjudicated.

Sincerely,

Claims Examiner

CA0143

INSTRUCTIONS RELATING TO REPRESENTATIVE FEE APPLICATIONS

The Federal Employees' Compensation Act, 5 U.S.C. 8101 et seq., provides that "A claim for legal or other services furnished in respect to a case, claim, or award for compensation under this subchapter is valid only if approved by the secretary." (5 U.S.C. 8127(b))

In each case where a representative's fee is desired, an application for approval of the fee must be submitted to the Office of Workers' Compensation Programs (OWCP). In order to eliminate the time lag between case approval/payment or disallowance and a formal ruling on the fee application, representatives should submit requests for fee approval at the time they submit the final evidence necessary for adjudication of their client's claim. Each fee application must include a complete itemized statement describing the necessary services rendered, including an estimate of the time required to review the award and communicate with the client. The itemization shall include the following:

(a) The dates that services began and ended, in addition to all dates conferences were held, documents or letters prepared, telephone calls made, etc.

(b) A description of each service rendered with the amount of time spent on each type of service.

(c) The total amount of the fee which the representative desires for services performed

(d) The hourly rate at which services were provided.

(e) The amount, if any, of the fee already collected or placed on escrow. If any portion of the requested fee has been placed on escrow, a copy of the escrow agreement must accompany the application for fee approval.

In addition, the representative is responsible for submitting a statement from the client, commenting on the application and the reasonableness and appropriateness of the fee requested. These comments are to be based upon the claimant's review of the fee request and itemization, which should be supplied to the client. The representative should submit this statement with the fee request. In those instances where this is not possible, the representative must advise of the manner and date on which the client was requested to submit such a statement. The representative should submit with the fee application, a copy of the communication sent to the client.

Where the representative has submitted a fee request in accordance with these requirements, a decision relative to the fee request will be issued. If any information as listed above is not provided, the fee request will be returned for proper completion. The collection of the fee is a

matter between the representative and the claimant.

No claim for a fee for services is valid unless prior approval is obtained from the OWCP. (20 CFR 10.702) Collection of a fee prior to such approval is a violation of 18 U.S.C. 292.

CA0155 Page 1

Public Burden Statement

You do not have to respond to this collection unless it displays a currently valid OMB number. We estimate that it will take an average of 1-1/2 hours to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this survey, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, Department of Labor, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

CA0155 Page 2

Attachment 2: Sample Letter

File Number:
Employee:

Dear :

We have received information that you are currently represented by REPRESENTATIVE'S NAME. It appears that this person may be a Federal employee. If this is the case, please note that under 18 U.S.C. 205 and 208, a Federal employee may only represent another injured Federal worker in regard to that worker's claim under the Federal Employees' Compensation Act (FECA) if the representative is either:

a. an immediate family member, defined as a spouse, child, parent, or sibling, and then only if no fee is charged, or

b. a union representative, and then only if an officially sanctioned union official also charging no fee or gratuity.

In light of this, it is necessary for you to provide a statement as to the nature of your relationship with your representative, so that his/her ability to represent you in relation to your FECA claim may be determined. If your representative is not a Federal employee, please provide a signed statement to that effect.

We will be unable to correspond with your representative regarding your case until we receive this information and reach a decision as to the appropriateness of this representative relationship. Should you have any questions, please feel free to contact me.

Sincerely,

Claims Examiner

Attachment 3: Form CA-1066

File Number:
Date of Injury:
Employee:

Dear :

This is in reference to your application for approval of a fee for services rendered in the compensation case of CLAIMANT NAME.

We have approved your fee of $XXXX.XX as requested for services rendered from 00/00/0000 to 00/00/0000. This fee has been approved because the claimant has not contested the reasonableness of the amount of the fee. Payment of the approved fee is the claimant's responsibility and HE/SHE is so advised by copy of this letter.

Pursuant to 5 U.S.C. 8127 and 20 CFR 10.702, a claimant is legally liable for only those fees for service that have been approved by this office. With respect to services rendered in this claim, any person who requests or receives a fee, gratuity, or other consideration which has not been approved by this office, may be subject to criminal prosecution.

If either party disagrees with this decision, either or both have the right to appeal to the Employees' Compensation Appeals Board (ECAB) for review of the decision. The claimant may also request hearing or reconsideration. These appeal rights are described on the attached sheet.

Sincerely,

Claims Examiner

Enclosure: ENAPPC

CA1066

FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

READ THIS NOTICE CAREFULLY AND DECIDE WHAT ACTION YOU WISH TO REQUEST: **REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD** (ECAB); **HEARING** (Oral or Written); or **RECONSIDERATION**.

Be sure to send your request to the right address.
You may not request more than one form of appeal at a time.

REVIEW BY EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)
CLAIMANT AND REPRESENTATIVE

If you believe that all available evidence has been submitted, you have the right to appeal to the Employees' Compensation Appeals Board for review of the decision. The ECAB will review only the evidence of record, and no new evidence may be submitted.

Any request for review by the ECAB should be made within 90 days from the date of this decision. Send it to:

> **Employees' Compensation Appeals Board**
> **U.S. Department of Labor**
> **200 Constitution Ave., N.W., Room N-2609**
> **Washington, D. C. 20210**

The ECAB may waive the failure to file within 90 days if you request review within one year from the date of this decision and show a good reason for the delay.

If you (the claimant) should request a hearing or reconsideration as described below, you may still request review by the ECAB. The 90-day period for requesting review by the ECAB will begin on the date of the hearing or reconsideration decision.

HEARING (CLAIMANT ONLY)

If your injury occurred on or after July 4, 1966, and you have not requested reconsideration (see below), you may request one of the following actions:

> **Oral hearing.** You will be able to present oral and written evidence in further support of your claim. The hearing will be informal and will be held in your area. You may authorize a representative for this hearing in writing should you choose.
>
> **Review of the written record.** You may submit written evidence, but you will not be asked to attend or give oral testimony. You will have this review instead of an oral

hearing. Any additional written evidence you want to submit must be sent with your request for review.

ENAPPC Page 1

OWCP hearing representatives conduct both oral hearings and reviews of the written record. To request an oral hearing or a review of the written record, you **must** write to:

Branch of Hearings and Review
Office of Workers' Compensation Programs
P. O. Box 37117
Washington, D. C. 20013-7117

State clearly whether you want an oral hearing or a review of the written record. Your request must be postmarked within 30 days of the date of this decision.

You will have the right to request reconsideration or ECAB review of the hearing representative's decision if you disagree with it.

You are not required to request a hearing as the first step in the appeal process. However, if you request reconsideration, you will not be entitled to an oral hearing or review of the written record (see 5 U.S.C. 8124(b)(1)).

RECONSIDERATION (CLAIMANT ONLY)

If you have more evidence or legal arguments which you believe apply to your case, you may ask the OWCP district office to reconsider this decision. Such a request must be made within one year of the date of this decision. The request should clearly state your grounds for requesting reconsideration. It should also include evidence not submitted before, such as medical reports or sworn statements, or legal arguments. The new evidence or legal argument should apply directly to the issue addressed by this decision.

Send your request for reconsideration and your new evidence or argument to **the district office at the address shown on the letter conveying this decision**. So that your new evidence is independently evaluated, your case will be reconsidered by OWCP staff other than those who made this decision.

ENAPPC Page 2

Attachment 4: Sample Letter

File Number:
Date of Injury:
Employee:

Dear :

We have received your recent submission of a fee request for services provided to CLAIMANT NAME.

Upon review of this package, it is noted that it is incomplete because it does not contain LIST MISSING ITEM(S).

Per 20 CFR 10. 703(a)(2), the Office of Workers' Compensation Programs cannot consider an incomplete fee request. As such, your submission is being returned to you. Please provide the missing item(s) and resubmit this request.

Should you have any questions regarding this matter, please contact me.

Sincerely,

Claims Examiner

FECA BULLETIN NO. 99-15

Issue Date: March 17, 1999

Expiration Date: March 16, 2000

Subject: New Regulations - Withdrawal of Claims

Background: On January 4, 1999, the new Federal Employees' Compensation Act Regulations became final. The final regulations codify the ability of a claimant or survivor to withdraw a claim for benefits prior to the adjudication of the claim.

Subpart 10.100(b)(3) conveys the ability to withdraw claims for traumatic injury at any time prior to adjudication. This includes short-form closure cases, which have not been formally adjudicated. Any continuation of pay paid will be charged to either sick or annual leave or become an overpayment with the employing agency at the choice of the claimant. Although a claim is withdrawn, the notice itself is not.

Subparts 10.101(a) and 10.105(a) apply the same rules for withdrawal to claims for occupational disease and survivor benefits as for traumatic injury claims.

Subpart 10.117(b) advises employing agencies that they may not compel any employee to withdraw a claim.

Reference: 20 CFR 10.100(b)(3), 20 CFR 10.101(a), 20 CFR 10.105(a) and 20 CFR 10.117(b)

Purpose: To inform OWCP staff and employing agencies of the ability for claimants and survivors to withdraw claims for compensation.

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Fiscal Personnel, Technical Assistants and Systems Personnel, and Hearing Representatives

Action: In any case where written notice of intent to withdraw a claim is received prior to the claim's adjudication, the claimant should be advised that the claim is now viewed as withdrawn. The attached letter is a sample for this purpose. The case file will then be coded as withdrawn and the paper file retained. To code a case as withdrawn, the following coding scheme will be used:

Adjudication Status:	SU
Case Status:	CL
Rep/Acc flag:	N

No ICD-9 code can (or should) be entered. This will cause all bills to fail edit 111, based on adjudication status. This edit can be overridden if payment is desired (i.e., if a CA-16 was issued prior to withdrawal). A note saying "pay no bills, claim withdrawn" should also be entered into the notes screen.

Employing agencies are not permitted to compel employees to withdraw claims. Should any staff person believe that such an incident may have occurred, district office management should be notified so that contact may be made with the employing agency to prevent future occurrences. If it is shown that an employee was compelled to withdraw his or her claim, the claim may be reinstated without further notice.

Training should be conducted on the above within 30 days of receipt of this bulletin.

Disposition: Retain until incorporated into 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)

Attachment

Dear:

I have received your written request to withdraw your claim. As your case file has not been adjudicated, this request is granted. The Office of Workers' Compensation Programs will take no further action in consideration of your claim.

Please note that any continuation of pay paid by your employer due to the filing of this claim may be converted to sick or annual leave at your choice. Should you choose not to do so, your employer may view any payments made as an overpayment.

Should you have any questions, please contact me.

Sincerely,

Claims Examiner

FECA BULLETIN NO. 99-16

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: New Regulations - Filing Notices and Claims; Submitting Evidence

Background: With regard to this subject matter, the filing of notices and claims for compensation and the submission of evidence, the new regulations have organized the information differently. This involved moving some of the sections previously included in Subpart B (topics related to the appeals process) to other subparts (Subparts G and H). The new regulations have divided the topics relating to giving notice and filing claims into actions required of the claimant (§§10.100 to 10.105), and actions required of the employer (§§10.110 to 10.113).

A change that has occurred with respect to the filing of notices is referred to in §§ 10.100, 10.101, and 10.105. It is now mentioned in those sections that an employer may file a notice of injury, occupational disease or death if the employee or survivor cannot do so. Another change that is noted in the above-mentioned sections is the fact that a claimant may withdraw his or her claim for traumatic injury, occupational disease, or survivor's benefits at any time prior to the determination of eligibility for FECA benefits. However, such withdrawal must be in writing and may not include withdrawal of the notice of injury, occupational disease, or death. This will be addressed further in FECA Bulletin 99-15.

The sections which discuss the Notice of Traumatic Injury (Form CA-1) and the Notice of Occupational Disease (Form CA-2), §§10.100 and 10.101, respectively, explain how to file these forms and provide the applicable time requirements for filing. These sections also provide the web site address (www.dol.gov./dol/esa/owcp.htm) for obtaining these forms. It is also important to note that §10.102, which describes the process for filing a wage-loss claim, contains several references to Form CA-8 for claiming additional wage loss, and to Form CA-20a as the supplemental medical report form. As these forms are no longer to be used, all references to them are to be deleted and the appropriate FECA forms (CA-7 and CA-20, respectively) are to be used instead. (FECA Bulletin 99-18 discusses the CA-7 form and its uses in greater detail.) The Correction to the Final Rule, published December 23, 1998, explains exactly how all of the deletions and insertions should occur.

Section 10.102 describes the process for filing a wage-loss claim, and § 10.103 the filing process for permanent impairment (Schedule Award) claims. Section 10.104 describes situations in which it is, or is not, appropriate to file a notice and claim for recurrence of disability, along with the type of evidence required to have a recurrence claim approved. Section 10.105 gives examples for the dependent survivor of the situations in which it is appropriate, and describes how to file a claim for survivor's benefits.

The actions to be taken by the employer with regard to the filing of notices and claims for traumatic injury, occupational disease or death are addressed in §§ 10.110 through 10.113. Sections 10.115 through 10.121 of this subpart address the evidence needed to establish the claimant's burden of proof, or OWCP's burden with regard to justifying a formal decision. The basic evidence necessary to establish a claim, and the additional evidence needed for submission by the claimant in occupational disease claims are described in §§ 10.115 and 10.116. Sections 10.120 and 10.121 discuss the claimant's opportunity to submit additional evidence if desired, and OWCP's burden to request additional evidence when necessary, allowing 30 days for the submission.

The information contained in §§ 10.117, 10.118, and 10.119 pertains to the employer's responsibility to provide requested evidence in order to assist in the claims process, and opportunities for the employer to participate by submitting factual and/or medical evidence when there is disagreement as to the validity of the claim and the employer wishes to contest it.

The last few sections of this subpart, §§ 10.125 through 10.127, discuss determinations on entitlement to benefits under the FECA, or formal decisions. There is a brief discussion of how OWCP arrives at the decision, what information a decision must contain, and advice as to whom the decision is sent.

Reference: FECA Circular 99-04; 5 U.S.C. §§ 8107, 8119, 8121, 8122(b); CA-1; CA-2; CA-5 and CA-5b; CA-2a; CA-7; and CA-20.

Purpose: To focus attention on this portion of the new regulations, especially with respect to the substantive changes and to the organization of Subpart B.

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

Action:

Training by the district offices on the subject matter of this FECA Bulletin should be incorporated into other training scheduled pertaining to the new regulations. This training should be accomplished within 30 days of receipt of this bulletin.

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. 1--Folioviews Groups A and D
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA BULLETIN NO. 99-17

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

Subject: Compensation Pay: Compensation Rate Changes Effective January 1999.

Background: In December 1998, the President signed an Executive Order implementing a salary increase of 3.10 percent in the basic pay for the General Schedule. The applicability under 5 U.S.C. 8112 only applies to the 3.10 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, 1999.

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, 1999. The new maximum compensation rate payable is based on the scheduled salary of a GS-15, Step 10, which is now $97,201 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 3, 1999	Minimum	Maximum
Monthly	$1,251.92	$6,075.06
Weekly	216.68	1,401.94
Daily(5-day week)	43.34	280.39

The basis for the minimum compensation rates is the salary of $15,023 per annum (GS-2, Step 1) and the basis for the maximum compensation rates is $97,201 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 $1,251.92, effective January 3, 1999. The maximum monthly compensation as provided by 5 U.S.C. 8133(e)(2) is increased to $6,075.06 per month.

Applicability: Appropriate National and District Office personnel.

Reference: Memorandum For Directors of Personnel dated December 1998; 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 3, 1999, 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, 1999.

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, 1999. 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

1/03/99	43.34-65.01	216.68-325.02	43.34	216.68	1,251.92
	43.34-57.79	216.68-288.91			

CA-843

1/03/99	280.39	1,401.94	(5,607.76)	6,075.06

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. 99-18

Issue Date: December 24, 1998

Expiration Date: December 23, 1999

Subject: Forms - Revised Form CA-7, "Claim for Compensation"

Background: One of the tasks of the ACPS reinvention team was to redesign Form CA-7. Extensive input was solicited and received from Federal employing agencies and OWCP field offices. A draft revised form was piloted in two district offices. Field offices submitted comments on the draft revised form. Based on further input, additional changes were made. The revised form has now been cleared by OMB and is ready for use.

The new form is different in several respects. It combines Forms CA-7 and CA-8, so that the Form CA-8 is now obsolete (along with Form CA-20a). Sections of the form are optional for continuing claims. The language and format have been simplified as much as possible. The claimant's portion includes a section for showing clearly what is being claimed (compensation for leave without pay, leave buy back, or schedule award). The claimant is instructed to submit a Form SF-1199A, "Direct Deposit Sign-Up" in addition to the CA-7. The pay rate and schedule sections have been altered to solicit more accurate information. The COP/leave sections on the employer's portion have been revised, and a Form CA-7a, "Time Analysis Sheet" is requested if COP or leave is intermittent. The return to work section was changed, and a section for comments was added.

Reference: FECA Procedure Manual, Chapter 2-0401.12.

Purpose: To notify all employees of the existence of a new Form CA-7, and provide revised procedures for handling the forms.

Applicability: All staff.

Actions:

Effective immediately, the revised Form CA-7 (copy attached), dated November 1998, replaces all prior versions of Forms CA-7 and CA-8.

In Section 4 of the revised form, the claimant is supposed to indicate whether the CA-7 is the first CA-7 filed for the injury in question or not. For purposes of TPCUP tracking, until changes are made to the TPCUP program, if the response in Section 4 is "Yes," the form will be tracked as a CA-7. If the response in Section 4 is "No," the form will be tracked as a CA-8. If there is no response in Section 4, the form should be tracked as a CA-7.

A supply of the new CA-7 has been ordered for each office. Upon receipt of the new form, all previous forms of the CA-7 and CA-8 must be discarded, as they are obsolete.

In all communications and training, employing agencies should be informed that the new CA-7 is to be used. However, older versions of the CA-7 and the CA-8 will continue to be accepted by the district offices if received.

5. The new CA-7 will be available to employing agencies through the Government Printing Office, stock number 029-016-00132-8, revision date November 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)

FECA BULLETIN NO. 99-19

Issue Date: January 4, 1999

Expiration Date: September 30, 1999

Subject: Comp Pay/COP--Sunday Premium Pay

Background: Section 636 of the Treasury and General Government Appropriations Act, 1998 (Public Law 105-61), prohibited any agency funded by appropriated funds from paying Sunday

premium pay to any employee who did not actually perform work on Sunday. This prohibition became effective on October 10, 1997. Section 624 of the Treasury and General Government Appropriations Act, 1999, as contained in the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105-277), has a similar provision.

In accordance with these two statutory provisions, as well as with a decision of the Federal Labor Relations Authority, Sunday premium pay must be excluded from an agency's calculation of COP where the employee did not actually work on the Sunday or Sundays included in the period of COP, even if the employee was scheduled to do so. This applies to an agency's payment of salary only and is reflected in OWCP's new regulations at 20 CFR §§ 10.216(a)(1) and 10.217.

Given the distinction between COP and compensation payments, Sunday premium pay that is paid to an employee for work actually performed on a Sunday during the 12 months prior to the effective date of any pay rate [selected pursuant to 5 U.S.C. 8101 (4)] will still be included in the employee's pay rate for compensation purposes, as required by 5 U.S.C. 8114.

We are aware of the interim regulations on Holidays and Premium Pay published by the Office of Personnel Management (OPM) on May 23, 1997 (but not yet made final). The preamble contains the following statement:

Similarly, this prohibition appears to preclude a covered agency from reimbursing the Department of Labor for FECA benefits paid to its employees to the extent that the employees have received FECA benefits that are based on Sunday premium pay or night pay differential that the employees would have earned had they worked, but did not earn because they did not actually work on Sunday or at night. The Department of Labor may be able to waive any overpayment that occurred. OPM believes that is an issue to be worked out between affected agencies and the Department of Labor.

(Night differential is addressed because, when this material was published, Public Law 104-208 prohibited the Department of the Treasury and the U.S. Postal Service from paying night differential pay as well as Sunday premium pay for hours not actually worked. However, night differential pay is not at issue at this time.)

OWCP and OPM have since discussed this matter further. OWCP takes the position that it is solely responsible for determining pay rates in claims under the FECA. Because OWCP believes inclusion of Sunday premium pay in such pay rates to be proper, and will continue to do so, there is no reason to consider invoking overpayment procedures. The amounts paid on this basis will continue to be charged back to employing agencies as usual.

Purpose: To provide guidance for claims and technical assistance staff concerning the effect of legislation barring payment of Sunday premium pay when work is not actually performed on

Sunday

Applicability: Claims Examiners, Senior Claims Examiners, Supervisors, Hearing Representatives, and Technical Assistants

Actions:

With Respect to COP:

1. Any claimant, employing agency, or other party who asks whether Sunday premium pay is included in payments of COP should be advised that after October 10, 1997, the effective date of Public Law 105-61, payments of COP must exclude Sunday premium pay for time not actually worked.

a. For periods prior to January 4, 1999, the effective date of the FECA program's new regulations, the reason is that while OWCP's regulations, at 20 CFR § 10.205(d), called for inclusion of this increment, Public Laws 105-61 and 105-277 require its exclusion.

b. For periods on or after January 4, 1999, the reason is that Public Laws 105-61 and 105-277 require its exclusion, and OWCP's regulations, at 20 CFR § 10.216(a)(1), allow for such exclusion. (That provision states that "The pay rate excludes overtime pay, but includes other applicable extra pay except to the extent prohibited by law".)

2. If a claimant disputes the amount of COP received on the basis that it excludes Sunday premium pay for time not actually worked, it will be necessary to issue a formal decision that affirms the lower rate. The decision should cite both OWCP's regulations and Public Law 105-61 or 105-277, as appropriate.

With Respect to Compensation Payments:

3. If the claimant regularly worked on Sunday, the Claims Examiner (CE) should compute Sunday premium pay on that basis, in accordance with current practice.

4. If the claimant did not regularly work on Sunday, the CE should compute Sunday premium pay on the basis of the Sunday premium pay earned during the year prior to date of injury, date disability began, or date of recurrence, as appropriate. If the employer has not reported these amounts, the CE should request a list of the specific days and hours involved and the hourly differential for each period of Sunday work performed.

5. Any questions about the effect on chargeback payments should be referred to the National Office.

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. 99-20

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

SUBJECT: ADP - Automated Compensation Payment System (ACPS) and Debt Management System (DMS) Report Schedule - 1999.

PURPOSE: To provide the 1999 schedule for processing the periodic disability and death payrolls under the ACPS and the DMS weekly and monthly reports for calendar year 1999.

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)

Attachment 1

AUTOMATED COMPENSATION PAYMENTS SYSTEM (ACPS) - 1999

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

Check Cycle	From Period of Entitlement To*	Bi-Weekly Pay Periods For Health and Life Insurance Purposes	District Office Cut-Off Date to Enter Roll Data	N.O. Trans-Mission to TREASURY
1	01/03/99 - 01/30/99	01/03/99 - 01/16/99	01/20/99	01/22/99
		01/17/99 - 01/30/99		
2	01/31/99 - 02/27/99	01/31/99 - 02/13/99	02/17/99	02/19/99
		02/14/99 - 02/27/99		
3	02/28/99 - 03/27/99	02/28/99 - 03/13/99	03/17/99	03/19/99
		03/14/99 - 03/27/99		
4	03/28/99 - 04/24/99	03/28/99 - 04/10/99	04/14/99	04/16/99
		04/11/99 - 04/24/99		
5	04/25/99 - 05/22/99	04/25/99 - 05/08/99	05/12/99	05/14/99
		05/09/99 - 05/22/99		
6	05/23/99 - 06/19/99	05/23/99 - 06/05/99	06/09/99	06/11/99
		06/06/99 - 06/19/99		
7	06/20/99 - 07/17/99	06/20/99 - 07/03/99	07/07/99	07/09/99
		07/04/99 - 07/17/99		
8	07/18/99 - 08/14/99	07/18/99 - 07/31/99	08/04/99	08/06/99
		08/01/99 - 08/14/99		
9	08/15/99 - 09/11/99	08/15/99 - 08/28/99	09/01/99	09/03/99
		08/29/99 - 09/11/99		
10	09/12/99 - 10/09/99	09/12/99 - 09/25/99	09/29/99	10/01/99
		09/26/99 - 10/09/99		
11	10/10/99 - 11/06/99	10/10/99 - 10/23/99	10/27/99	10/29/99
		10/24/99 - 11/06/99		
12	11/07/99 - 12/04/99	11/07/99 - 11/20/99	11/24/99	11/26/99
		11/21/99 - 12/04/99		
13	12/05/99 - 01/01/00	12/05/99 - 12/18/99	12/22/99	12/23/99
		12/19/99 - 01/01/00		

*ENDING PERIOD IS THE CHECK DATE
FOR EFT PAYMENTS, THE DAY BEFORE

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

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

**FOR EFT PAYMENTS, EACH FRIDAY

Attachment 2

DEBT MANAGEMENT REPORT SCHEDULE 1999

01/04/1999	**MONTH END PROCESSING (12/31/1998)**
01/05/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/26/1998 - 01/01/1999)
01/11/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/02/1999 - 01/08/1999)
01/19/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/09/1999 - 01/15/1999)
01/25/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/16/1999 - 01/22/1999)
02/02/1999	**MONTH END PROCESSING (01/31/1999)**
02/03/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/23/1999 - 01/29/1999)
02/08/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/30/1999 - 02/05/1999)
02/16/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/06/1999 - 02/12/1999)
02/22/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/13/1999 - 02/19/1999)
03/01/1999	**MONTH END PROCESSING (02/28/1999)**
03/02/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/20/1999 - 02/26/1999)
03/08/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (02/27/1999 - 03/05/1999)
03/15/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/06/1999 - 03/12/1999)
03/22/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/13/1999 - 03/19/1999)
03/29/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/20/1999 - 03/26/1999)
04/01/1999	**MONTH END PROCESSING (03/31/1999)**
04/05/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (03/28/1999 - 04/02/1999)
04/12/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/03/1999 - 04/09/1999)
04/19/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/10/1999 - 04/16/1999)
04/26/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/17/1999 - 04/23/1999)
05/03/1999	**MONTH END PROCESSING (04/30/1999)**
05/04/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (04/24/1999 - 04/30/1999)

05/10/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/01/1999 - 05/07/1999)

05/17/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/08/1999 - 05/14/1999)

05/24/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/15/1999 - 05/21/1999)

06/01/1999 **MONTH END PROCESSING (05/31/1999)**

06/02/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/22/1999 - 05/28/1999)

06/07/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (05/30/1999 - 06/04/1999)

06/14/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/05/1999 - 06/11/1999)

06/21/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/12/1999 - 06/18/1999)

06/28/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/19/1999 - 06/25/1999)

07/01/1999 **MONTH END PROCESSING (06/30/1999)**

07/06/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (06/26/1999 - 07/02/1999)

07/12/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/03/1999 - 07/09/1999)

07/19/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/10/1999 - 07/16/1999)

07/26/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/17/1999 - 07/23/1999)

08/02/1999 **MONTH END PROCESSING (07/31/1999)**

08/03/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/24/1999 - 07/30/1999)

08/09/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (07/31/1999 - 08/06/1999)

08/16/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/07/1999 - 08/13/1999)

08/23/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/14/1999 - 08/20/1999)

08/30/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/21/1999 - 08/27/1999)

09/01/1999 **MONTH END PROCESSING (08/31/1999)**

09/07/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (08/28/1999 - 09/03/1999)

09/13/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/04/1999 - 09/10/1999)

09/20/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/11/1999 - 09/17/1999)

09/27/1999 WEEKLY CASH RECEIPTS/INTEREST REPORT (09/18/1999 - 09/24/1999)

10/01/1999	**MONTH END PROCESSING (09/30/1999)**
10/04/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (09/25/1999 - 10/01/1999)
10/12/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (10/02/1999 - 10/08/1999)
10/18/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (10/09/1999 - 10/15/1999)
10/25/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (10/16/1999 - 10/22/1999)
11/01/1999	**MONTH END PROCESSING (10/31/1999)**
11/02/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (10/23/1999 - 10/29/1999)
11/08/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (10/30/1999 - 11/05/1999)
11/15/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/06/1999 - 11/12/1999)
11/22/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/13/1999 - 11/19/1999)
11/29/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/20/1999 - 11/26/1999)
12/01/1999	**MONTH END PROCESSING (11/30/1999)**
12/06/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (11/27/1999 - 12/03/1999)
12/13/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/04/1999 - 12/10/1999)
12/20/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/11/1999 - 12/17/1999)
12/27/1999	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/18/1999 - 12/24/1999)
01/03/2000	**MONTH END PROCESSING (12/31/1999)**
01/04/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (12/25/1999 - 12/31/1999)
01/10/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/01/2000 - 01/07/2000)
01/17/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/08/2000 – 01/14/2000)
01/24/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/15/2000 - 01/21/2000)
01/31/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/22/2000 - 01/28/2000)
02/01/2000	**MONTH END PROCESSING (01/31/2000)**
02/07/2000	WEEKLY CASH RECEIPTS/INTEREST REPORT (01/29/2000 – 02/04/2000)

FECA BULLETIN NO. 99-21

Issue Date: January 4, 1999

Expiration Date: January 3, 2000

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

Background: A fee schedule for inpatient hospital bills, based on the Medicare system of Diagnosis-Related Groups (DRGs) will be in effect for all bills processed on or after January 4, 1999. To be able to obtain the information needed to process inpatient hospital bills in this manner, it was necessary to make several modifications to the Medical Bill Processing System.

Inpatient hospital bills (with one very limited exception) will no longer be data entered onto Sequent using the FECS001 Bill Input program. Instead, these bills will keyed into a stand-alone computer, using special software. The data will then be transmitted through several intermediaries for processing, and eventually returned to the district office and loaded into the bill tables, where it will be subjected to the revised BILL552 edits, and will then be available for bill resolution, as needed.

In addition to OWCP keying inpatient hospital bills using special software, the hospitals themselves will be able to submit inpatient bills electronically, through an intermediary.

Reference: Federal (FECA) Procedure Manual Chapters 5-0200, 5-0201, 5-0203, 5-0204, and 5-0205; 20 C.F.R. Part 10, Subpart I, published November 25, 1998; FECA Bulletin 99-7.

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

Applicability: All staff.

Actions:

1. Effective January 4, 1999, inpatient hospital bills should be separated from other bills in the mailroom, insofar as possible. Inpatient hospital bills should be on Form UB-92, and should contain room charges. The locator 4 code for inpatient bills most commonly starts with 11* or 12*.

For a limited period of time, until further communication is received from National office, all of the inpatient hospital bills should be placed in bill batches separately from other bills, assigned a batch identification number which is not being used for another batch, and immediately imaged. These batches should include bills for third party and claimant reimbursement, as described in item 19 and Attachment 2, unless the bill is being keyed into the Sequent FECS001 Bill Input program. A daily e-mail from each district office should be sent to William Cole, Chief of Coordination and Control at the National Office, at wfc@fenix2.dol-esa.gov, listing the batch identification number for the imaged inpatient bill batch. One bill batch per office per day will usually be sufficient. The batch cover sheet should show the number of bills in the batch.

3. The National Office will key the bills from the images, after which they will be processed through the intermediaries, and then loaded into the district office systems for editing, bill resolution, and final processing.

4. After each district office has completed training on the new software for inpatient hospital bills, and the go-ahead has been sent by National Office, inpatient bills will no longer be keyed by National Office. The inpatient hospital bills will be given to the individual(s) who have been assigned to data enter inpatient hospital bills on the special software. Training on how to use the software is being provided separately.

5. The inpatient hospital bills may be data entered using the office's existing batch identification scheme. However, extreme caution must be taken to ensure that the batch numbers are entered accurately, and are not used for other bill batches.

6. The special data entry software does not interact with the Sequent system, therefore, accuracy of data entry is critical.

7. The practice of keying outpatient bills from the Department of Veterans Affairs and other federal agencies that are exempt from the fee schedule as inpatient bills will not be allowed. Rather, these bills should be keyed as outpatient bills, using the FECS001 Bill Input program. A fee schedule appeal code of "B," for bypass, should be keyed as the eighth character of the procedure code on each line item (appeal code), so that the fee schedule is not applied.

8. Only bills with certain locator 4 codes will be allowed in the special software. The first number must be 1, 4, or 8; the second number 1, 2, 5, 7 or 8; and the third number 1, 2, or 7. Bills with other locator 4 codes must be data entered in FECS001 bill input as an outpatient bill, or as a different provider type.

9. The FECS001 "Bill Input" program has been modified to block data entry of an inpatient hospital bill, with only one exception (see item 24 below).

Once the inpatient hospital bill has been data entered on the special software, it will be transmitted for grouping (assign a Diagnosis-Related Group) and pricing the bill according to HCFA rules and DFEC's modifications.

11. Following this, the data will be transmitted to the National Office, along with any error codes that arise from the processing. There are three types of error codes that may be assigned: MCE (Medicare Code Editor) errors, grouper errors, and pricer errors. Not all error codes will result in the bill not being payable, as some of the error codes are used by payers other than FEC. Some of the pricer error codes will result in National Office having to compute the allowable fee, based on an alternate formula, which uses the state's average cost-to-charge ratio. The error codes that are significant in terms of district office processing have been incorporated into the BILL552 edits.

12. The National Office will maintain a data file of hospital providers, which will be used to populate the address fields in the bill records. If the tax identification number and Medicare number on the bill record match a record of the National Office hospital file, the address from the file will be placed on the bill record and the address OK flag set to Y for "yes". If the tax identification number and Medicare number on the bill record do not match a record on the National Office hospital file, the address (if any) on the bill record will be retained and the address OK flag set to N for "no". This will cause BILL552 edit 024 to fail. See action item 19 for further information.

13. After the National Office has received and processed the bill, it will be sent to the owning district office, according to the NCMF, and loaded into the bill tables. If a case has been transferred between the time the bill was keyed into the special software and the time the bill is received in the National Office, it will be sent to the new owning office.

Along with bills that have been keyed in the district offices (or initially, National Office) using special software, bills that have been submitted electronically will also be transmitted. Electronic inpatient hospital bills will have batch identification numbers beginning with EDH.

Once the bills are loaded into the district office tables, they will be edited by the BILL552 program. If district office intervention is required, they will suspend for review.

16. Forty-four (44) new edits have been added to BILL552 to accommodate the changes for inpatient hospital bills. Most of these new edits are for MCE/grouper/pricer error codes. All of the MCE/grouper/pricer code edits are in the 400's, starting with 413. Three (3) edits have been added which are based on the DRG alone (352, 353, and 356). Five edits have been added to address the relationship of the assigned DRG to the accepted conditions (754, 757, 758, 764, and 766). One new edit (212) ensures that bills other than hospital bills do not have locator-4 codes associated with them. Edits 001 through 004 have been modified, as have the duplicate edits, 801 through 805. Detailed information of the new and revised edits is being provided under

separate cover.

17. The grouping and pricing performed on each inpatient hospital bill is based on information that is provided by the hospital on the UB-92 form, and on information that is maintained by HCFA concerning characteristics of the individual hospital. Several new data elements were required to capture this information. The new data elements have been placed into a new data table (d28). The information may be viewed by using "Inpatient Hospital Bill Query" under the FECS001 Bill Payment and Query menus. This information can also be accessed from within the bill resolution and suspended bill query programs by pressing a function key. A sample screen is shown as Attachment 1.

Because inpatient hospital bills are being grouped and priced by an outside entity, once the bills have been loaded onto the Sequent system, the data fields that can be changed are very limited. In bill resolution, the only fields that may be modified are:

HEADER SCREEN
- Authorizing initials
- Errors box
- Direct Payment Flag
- Provider address OK flag

LINE ITEM SCREEN
- Ineligible amount
- Ineligible amount code
- Bypass code
- Fee schedule appeals code
- Errors box

PROVIDER SCREEN
- Address OK flag

The system will block changes to other fields. In most instances, if a keying error was made by the district office, the bill will have to be internally denied, corrected in the special software, and reprocessed under a new batch ID. If the hospital submitted the bill electronically with erroneous data, usually it will be denied automatically with an instruction to resubmit with corrected information.

19. For EDI inpatient hospital bills, the provider screen (in bill resolution) initially shows the provider name and address information from the bill record. The user has the ability to query the district office provider file, to determine whether the address on the bill record matches an address of a provider already on the provider file. Viewing the provider file records for EDI bills does not alter the name and address information on the bill record. If edit failure 024 has been

assigned, the user should cycle through the provider addresses and if a match is found, change the address OK flag to Y. If no match is found, a narrative letter should be sent to the provider at the address on the bill record, asking for written verification of their billing address, tax identification number, and Medicare number. Once their response has been received, the provider may be added to the provider file, and the above actions taken.

For non-EDI inpatient hospital bills, normal access to the provider screen is allowed, except that the tax identification number and zip code cannot be changed. Thus, if edit failure 024 has been assigned, with the paper bill in hand (or an image of the paper bill), the user may select a matching provider from the provider file, change the address OK flag to Y if a match is found, and automatically update the bill record with that information.

20. Inpatient hospital bills that are submitted by third parties (such as insurance companies) or claimants for reimbursement will require special handling. In principal, reimbursements to third parties and claimants should not exceed the lesser of the DRG-based price or the amount actually paid. Detailed instructions for handling bills of this nature are shown in Attachment 2.

Disputes regarding the assigned DRG or price (based on the DRG) should be referred in writing to OWCP's Branch of Medical Standards and Rehabilitation, at the following address:

Dr. Virginia Miller - DRG Dispute
U.S. Department of Labor, ESA, OWCP
200 Constitution Ave., N.W. Rm. S-3522
Washington, DC 20210

Keep in mind, however, that most hospitals are already familiar with a DRG-based system through Medicare, and that the DFEC's new fee schedule rates of payment are higher than Medicare, on the average.

22. The DRG system is much more complicated than outlined herein. Attachment 3 lists additional resources that are available.

23. The MCE/grouper/pricer error codes are shown in Attachment 4, along with explanations.

24. Under special circumstances, an inpatient hospital bill may be entered under the FECS001 Payment Input program by using a locator-4 code of 911. However, a locator-4 code of 911 should be used only when it is not possible to handle the bill by using the process described above. Before a bill is data entered using a locator-4 code of 911, written supervisory approval must be obtained. One example of when 911 may be used is when the claimant has paid all or part of a bill, and the hospital is also claiming payment, as found in Attachment 2. Other circumstances that would warrant use of locator-4 code 911 should be extremely rare.

Training on these procedures should be completed prior to January 15, 1999.

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)

Attachment 1

INPATIENT HOSPITAL BILL INFORMATION QUERY

CASE NO: **010111111** BATCH ID: **ABC123** BILL ID: **001**

PAYEE NO: 555555555
PRINCIPAL DX: 831
OTHER DX: 8251 74764 111 252

PRINCIPAL PROCEDURE: 818
OTHER PROCEDURE: 111 222

DRG CODE: 311

DRG AMOUNT: $ 6500.00
DATE OF BIRTH: 02/01/1940 SEX: M DISCHARGE STATUS: 01

PROVIDER MEDICARE NUMBER: 123456

GROUPER RETURN CODE : G0
GROUPER MCE ERROR CODES: M4 M5 M6 M7 M8
GROUPER PRICER ERROR CODES: 51 52 53 54 55
PRIOR PAYMENT AMOUNT: 0.00

VIEW NEXT RECORD? [Y/N]

FECA Bulletin 99-21 Attachment 1

Attachment 2

INPATIENT HOSPITAL BILLS - HOW TO PROCESS PAYMENTS BY THIRD PARTIES AND CLAIMANT REIMBURSEMENTS

Inpatient hospital bills present unique difficulties with respect to third party and claimant reimbursements, due to the need to limit the payment amount to the lesser of the DRG amount or the paid amount, and the DRG amount being dependent on hospital provider-specific information that is contained only in the pricer.

Reimbursement claims from third parties (such as insurance companies):

Will be accepted as paper billing only.

The claim should consist of a UB-92 completed by the hospital which provided the services, and a claim from the third party payer, showing the amount and date paid.

The bill will be entered into Premis as an inpatient hospital bill, with the hospital as a provider.

The amount paid by the third party insurance company will be shown as a prior payment amount. The prior payment amount will be loaded as an ineligible amount in b21.

The bill will be grouped and priced in the usual manner.

The presence of the prior paid amount will cause the direct pay flag to be loaded as N in b20.

The N direct pay flag will cause the bill to suspend with edit failure 210.

If the DRG amount assigned is less than the prior paid amount, the bill will be internally denied. The bill will be rekeyed as a direct payment to the third party payer (provider type O), with the DRG amount as the bill total, the third party paid amount as the line charge, and the difference between the two as an ineligible amount, ineligible amount code I.

If the DRG amount assigned is greater than the third party paid amount, and the hospital has not also made a claim, the bill should be internally denied. A new bill as direct payment to the third party (provider type O) should be keyed in BILL001, with the third party paid amount as both the line charge and the bill total.

If the DRG amount is greater than the third party paid amount, and the hospital has also made a claim, the bill should not be internally denied. The direct pay flag should be changed to Y, and the bill processed (the hospital will be paid the difference between the DRG amount and the prior paid amount. A second payment as noted in item 9 above should be processed for the third party payer. The total of the payment to the hospital and the payment to the third party should not exceed the DRG amount.

Reimbursement claims from claimants (injured employees):

Claimants should not be reimbursed for charges for which they are personally responsible, such as television or private room differential (where not medically necessary).

Paper bills only will be accepted. Paper bills should consist of a completed UB-92 from the hospital, with a completed form CA-915 or another written request for reimbursement, and proof of payment.

The bill should be entered on Premis, with the claimant paid amount as a prior paid amount. The prior payment amount will be loaded as an ineligible amount in b21.

The bill will be grouped and priced in the usual manner.

The presence of the prior paid amount will cause the direct pay flag to be loaded as N in b20.

The N direct pay flag will cause the bill to suspend with edit failure 210.

If the DRG amount is less than the claimant paid amount, delete the prior payment amount. The claimant will get the DRG amount. A separate letter should be sent to the claimant, explaining that the paid amount exceeded the allowable fee, and so only a partial payment was made.

If the DRG amount is more than the claimant paid amount, and the hospital has not also made a claim, enter the difference between the two as an ineligible amount, ineligible code [new]. The claimant will be paid the amount they actually paid (less than the DRG amount).

If the DRG amount is more than the claimant paid amount, and the hospital has also made a claim, change the direct pay flag to Y, and continue processing. A second bill should be entered in BILL001 as an indirect hospital bill payment, using a 911 locator 4 code and procedure code 001. The bill total and line charge will equal the claimant paid amount.

The sum of the payment to the hospital and payment to the claimant should not exceed the DRG amount.

FECA Bulletin 99-21 Attachment 2

Attachment 3

DRG INFORMATION RESOURCES

DRGs Diagnosis Related Groups
Definition Manual, Version 16.0
Available from: 3M Health Information Systems
100 Barnes Rd.
Wallingform, CT 06492

Voice # (203) 949-0303

42 CFR parts 405,412,413
Vol.63, No. 147, July 31, 1998

On the internet, HCFA's site at www.hcfa.gov has a wide variety of information.

FECA Bulletin 99-21 Attachment 3

Attachment 4

MEDICARE CODE EDITOR (MCE) ERRORS

Error Code	Error	Explanation
M1	invalid code	A DRG can not be assigned if there is a not a valid ICD-9-CM procedure or diagnosis code.
M2	sex conflict	There is a conflict between sex and procedure or diagnosis codes
M3	age conflict	A DRG can not be assigned if there is a conflict between age and procedure or diagnosis codes.
M4	Questionable admit	A DRG can be assigned but admission is questionable under Medicare rules.
M5	Manifestation pdx	A DRG can not be assigned. The diagnosis code describes a manifestation of a disease, not the disease itself.
M6	non-specific pdx	A more specific pdx could have been provided but Grouper can assign a DRG.
M7	e-code pdx	A DRG can not be assigned. E-codes are not acceptable as principal diagnosis.
M8	invalid 4/5 digit	Grouper will not assign a DRG if there is an invalid or missing 4th or 5th digit in the diagnosis code.
M9	non-specific	A more specific procedure code is

	o.r. proc	preferred, but Grouper will assign a DRG.
MA	open biopsy check	Warning of possibility of coding error for open rather than closed biopsy. Grouper will assign a DRG for an open biopsy procedure code.
MB	non-covered o.r. procedures	This error/alert is generated if procedures are not covered by Medicare. A DRG can be assigned.
MC	unacceptable pdx	A DRG can not be assigned if the principal diagnosis code provided is not a current illness or injury.
MD	sdx dup of pdx	The duplicate sdx may cause assignment to a complication/comorbidity DRG in error. A DRG can not be assigned.
ME	mcare secondary payor alert	This is an ALERT. The alert is not likely applicable to DFEC claims. A DRG can be assigned.
MF	bilateral procedure check	This is a warning of a possible procedure code error. A DRG can be assigned.
MG	requires secondary dx	Requires a secondary diagnosis to assign a DRG.
MH	o.r. procedure	Error associated with a procedure.
MI	pre-pay error	Error should be resolved prior to payment.
MJ	post-pay error	Potential discrepancy or error can be resolved after payment has been made.

GROUPER ERROR CODES

RTC	Error	Explanation
G1	Diagnosis code cannot be used as principal dx.	A DRG could not be assigned. The diagnosis code can not be used as the principal diagnosis code. The principal dx describes a circumstance which influences health status but is not an illness or injury.
G2	Record does not match criteria for any DRG in MDC indicated by the pdx	A DRG could not be determined for the principal diagnosis.
G3	invalid age	A DRG could not be assigned. The age of the patient submitted on the claim was not between 0 and 124.
G4	invalid sex	A DRG could not be assigned. Must be 1 (male) or 2 (female).
G5	invalid discharge status	The discharge status was not one of the valid HCFA 1450 discharge status codes. A DRG could not be assigned .
G6	Illogical principal diagnosis code	A DRG could not be assigned due to a principal diagnosis code that could not be grouped.
G7	Invalid principal diagnosis code	A DRG could not be assigned due to a principal diagnosis code that was not valid. Diagnosis code does not exist.
G8	"Catch all"	No standard explanation of why a DRG could

	error	not be assigned.

PRICER ERROR CODES

Error Code	Error Description	Explanation
51	no provider specific information found	Provider information is not found in HCFA provider file. Price calculated by National Office fee.
52	invalid metropolitan status area (msa) # in provider file	Invalid MSA status area in HCFA provider file. Price calculated by National Office.
53	waiver state - not calculated by pps	Some states are exempt from PPS. Price calculated by National Office.
54	drg < 001 or > 494, or = 109 or 438 or 469 or 470 or 474	Price could not be calculated. A valid DRG could not be assigned based on the data submitted on the claim.
55	discharge date < provider pps start date	Price calculated by National Office.
56	invalid length of stay	
57	review code invalid (not 00 03 06 07)	Price calculated by National Office.
58	total charges not numeric	Possible data entry error.

61	lifetime reserve days not numeric	Price calculated by National Office
62	invalid number of covered days	Possible keying error.
65	pay code not = A, B or C on provider specific file for capital	Price calculated by National Office.
67	cost outlier with length of stay (los) > covered days	Price calculated by National Office.
98	cannot process bill older than 5 years	Price calculated by National Office.

FECA BULLETIN NO. 99-22

Issue Date: January 26, 1999

Expiration Date: January 25, 2000

Subject: Medical Examinations: Obstruction/Refusal - Suspension under Section 8123(d)

Background: A recent FECA Transmittal, 99-05, regarding the above subject provided the correct information on the procedure manual change, but included an example in the transmittal that was misleading. The example given in FECA Transmittal 99-05 is hereby retracted and another example will be provided below. The points of confusion appear to have been in establishing when the obstruction officially began and when it stopped, for the purposes of establishing the period of entitlement to compensation. The Act, at § 8123(a), states that the employee shall submit to a medical examination once injured as frequently and at the times and places required by the OWCP. The Act at § 8123(d) goes on to state that if an employee refuses to undergo an examination or otherwise obstructs the exam, his or her right to compensation under the FECA will be suspended until the refusal or the obstruction stops.

The FECA Procedure Manual at Chapter 2-810.14.a. quotes from 8123(d), and then adds that prior to invoking the suspension penalty, the CE must ensure that the claimant has been afforded due process. Subparagraphs b., c., and d. go on to spell out what constitutes sufficient notification and the actions that need to be taken by the CE in order to provide due process to the claimant. This includes providing a written warning as to the penalty (at the time notification of the appointment is sent out) if the claimant fails to appear for the scheduled examination. The actual failure to appear for the medical examination scheduled by the Office without giving sufficient explanation for such failure to appear is what constitutes refusal of an examination. In such a case, the period of obstruction begins on the date of the examination for which the claimant failed to appear. This would also constitute the beginning date for the suspension of compensation benefits. On the other hand, stating that one will not attend, but later attending the exam as scheduled, for whatever reason, does not constitute a refusal or obstruction and thus no penalty may be imposed by the Office.

Reference: FECA Bulletin 99-05; 5 U.S.C. 8123(d); Chapter 2-810.14.a., b., c. and d.

Purpose: To clarify what constitutes an obstruction or refusal, and what qualifies as the cessation of an obstruction/refusal for setting the effective date for reinstatement of benefits once

an obstruction of a medical examination has ceased.

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

Action:
1. If it is determined necessary for the claimant to submit to a medical examination (for a second opinion or an impartial evaluation), the CE or MMA must arrange for the examination with the medical specialist and the claimant in writing as described in 2-810, 14.b. The letter used for this purpose must contain a warning that benefits may be suspended under 5 U.S.C. 8123(d) for failure to report for examination.

2. In cases where no medical report is received within 30 days of the date of the appointment, or where the examiner learns by another means that the claimant may not have attended the scheduled examination, the CE should verify by telephone that the claimant reported for the examination, and, if so, should inquire as to when the report may be expected.

3. If the claimant failed to appear for the examination, the CE must request in writing that an explanation be provided within 14 days as to why the claimant did not attend. If the claimant does not provide a sufficient reason justifying the failure to appear for the examination, i.e., good cause is not established, the CE can then find that the claimant refused to attend an examination scheduled by the OWCP. Compensation should then be suspended effective the date the examination was scheduled in accordance with § 8123(d) of the FECA. The suspension period extends from the date of the failure to appear for the exam until the date the claimant agrees to attend the examination.

4. Once the claimant actually appears for the rescheduled examination, the CE should restore benefits retroactively to the date the claimant agreed that he or she would attend the exam.

Example: A second-opinion examination was scheduled by the CE with the specialist and the claimant for December 17th and the claimant was notified by letter of November 24th. The scheduling letter included notification of the claimant's responsibilities regarding attendance at a medical examination scheduled by OWCP. The claimant notifies OWCP that he or she will not appear for the examination (or simply fails to attend). The CE would verify that the claimant did not attend the examination, and then would ask for an explanation as to why the claimant refused to attend (or had failed to attend) the examination. If the claimant provides an explanation that is sufficient to show good cause for his or her nonappearance at the scheduled examination, the CE would allow compensation to continue uninterrupted, and a new examination would be scheduled. However, if the explanation fails to establish good cause, the CE would suspend benefits effective the date of the scheduled examination (or December 17th).

The claimant subsequently agrees to appear for the medical examination either in writing or via the telephone (documented by a CA-110). The date of the letter of agreement or the CA-110 is January 19th, and the CE therefore reschedules the examination for the first available appointment, February 19th. The examination is carried out according to the arrangement and the CE verifies the claimant's attendance on February 22nd.

The CE can then set up a payment to restore benefits effective January 19th. The period of suspension in this example would then be from December 17th through January 18th.

Chapter 2-810 14.d. adds that the claimant's statement that he or she will not appear for an examination is insufficient to invoke the penalty of suspension under 8123(d) of the FECA (see Leanna Garlington, 37 ECAB 849). Similarly, the claimant's refusal to schedule an examination at the direction of OWCP is also not sufficient to invoke the penalty (see Herbert L. Dazey, 41 ECAB 271).

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. 1--Folioviews Groups A and D
(Claims Examiners, All Supervisors, District Medical Advisors, Systems Managers, Technical Assistants, Rehabilitation Specialists, and Staff Nurses)

FECA BULLETIN NO. 99-23

Issue Date: March 1, 1999

Expiration Date: February 29, 2000

Subject: Comp Pay/ACPS - Consumer Price Index (CPI) Cost-of-Living Adjustments for March 1, 1999.

Purpose: To furnish instructions for implementing the CPI adjustments of March 1, 1999.

1. The new CPI increase, adjusted to the nearest one-tenth of one percent, is 1.6 percent.

2. The increase is effective March 1, 1999, and is applicable where disability or death occurred before March 1, 1998.

3. The new base month is December 1998.

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

$ 6,075.06 per month
1,401.94 per week
5,607.76 each four weeks
280.39 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 19, 1999, 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, 1999 and the start date of the periodic and death payroll cycles is February 28, 1999, there will be a supplemental record

created for the period March 1 through March 27, 1999. Effective March 28, 1999, the periodic and death payrolls will reflect the increased amount.

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 19, 1999, 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, 1999.

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 upon specific request by a District Office.

d. If claimants write or call for verification of the amount of compensation paid (possibly for mortgage verification; insurance verification; loan application; etc., please provide this data in letter form from the district office. Many times 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)

Attachment

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%
		03/01/99	1.6%

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. 99-24

Issue Date: February 9, 1999

Expiration Date: February 8, 2000

Subject: Medical Evidence: Appropriate Contact with Medical Specialists

Background: It has come to our attention that surveillance video tapes of claimants obtained by their employing agencies (EAs) are sometimes handled without the appropriate control by OWCP in situations involving medical opinions sought by the Office. More and more we have been made aware of situations in which employing agencies have made surveillance video tapes to be used as evidence in FECA claims, but have sought to contact our medical specialists directly without clearing the contact through OWCP. It is imperative that any surveillance video tapes of claimants under the FECA which are being used or considered as evidence are made a part of the official case record. As part of the official case record, the surveillance video tapes must be made available for review by the claimant or his or her representative upon request.

Reference: Federal (FECA) Procedure Manual Chapter 2-810, paragraph 13.(a).

Purpose: To provide guidance on the handling and disposition of surveillance video tapes by OWCP personnel; and to ensure appropriate contact with medical specialists by the Office with specific regard to providing video taped evidence for their review.

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

Actions:

1. If surveillance video tapes are submitted to the Office by the EA and the CE determines that it is relevant to the issue being resolved by the medical examination, the CE should obtain copies of the video tape for the case record.

2. The CE should initially attempt to get the EA to substitute still pictures which show the activity that it is attempting to focus upon. (This will facilitate both storage in the case record and review of the evidence by the medical specialist.) In the event that still pictures are not possible, the CE should review the video tape and require the EA to edit it to omit having a

medical specialist review hours of activity which has no bearing on the issue being considered. Once this is accomplished, the Office will make a copy of the edited video tape, labeling it as such (edited copy), and return the original to the EA.

3. If, on the other hand, upon review of the video tape the CE determines that the information is not relevant to the issue at hand, the video tape should be sent back to the EA with an explanation as to why it is determined not relevant to the issue at hand. (The CE should document the case record to reflect this action.)

4. If the CE determines that the video tape will be used as evidence for the record, he or she will direct the specialist involved to review the video tape and to reference this in his or her medical report.

5. If, somehow, the video tape goes to the second-opinion specialist directly from the employers' IG or Inspection Service, the CE will request a copy of the video for the case record from the EA. If the EA does not provide the video to the Office, the CE will direct the second-opinion specialist to disregard the video tape in coming to his or her opinion.

6. If evidence from a surveillance video tape is used in an Office decision, either directly or indirectly, the CE must reference it in the decision.

7. If, somehow, a surveillance video tape is provided by the EA directly to a medical specialist acting in the capacity of a referee physician, the CE must then advise the EA that the physician's opinion has been tainted and will have to be excluded from consideration in the Office's decision. If the EA insists convincingly that the evidence in the video tape in question about the claimant is vital to the case and must be used, the CE would direct the EA to send a copy of the video tape that they provided to the now-tainted referee, and then use it in conjunction with the referral to a new referee specialist.

8. When placement or maintenance of the video tape(s) becomes cumbersome or impossible as part of the physical case record, adequate provision for safeguarding the tape(s) must be made in the DD’s or ADD’s office. Similarly, reference to the existence and location of the tape(s) must be placed prominently in the case record itself.

9. When the district offices send cases with video tapes to Hearings and Review or ECAB, the presence of a video tape must be noted on the CA-58. When copies of video tapes are made by the Office, the copies must be labeled as such, adding that the original is owned and in the possession of the employing agency.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual Part 2 Chapter 810.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 99-25

Issue Date: April 1, 1999

Expiration Date: March 31, 2000

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

Background: Effective April 1, 1999, the mileage rate for reimbursement to Federal employees traveling by privately-owned automobiles is decreased to 31 cents per mile by GSA. No restriction is made as to the number of miles that can be traveled. As in the past, determination has been made to apply the applicable rate to disabled FECA beneficiaries traveling to secure necessary medical examination and treatment.

Applicability: Appropriate National Office and District Office personnel.

Reference: Chapter 5-0204, Principles of Bill Adjudication, Part 5, Benefit Payments, Federal (FECA) Procedure Manual; Instruction CA-77, Instructions for Submitting Travel Vouchers; and 5 USC 8103.

Action: Instruction CA-77, Instructions for Submitting Travel Vouchers, has been revised to reflect the indicated rate change. A copy of the revised instructions is attached to this bulletin and may be reproduced at local levels. It will not be necessary to search and locate vouchers processed subsequent to April 1, 1999; however, if inquiry is received, appropriate adjustment should be made. Vouchers being processed for travel periods after April 1, 1999, may be adjusted to reflect this increase.

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

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

Attachment

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

Attachment: Instructions for Submitting Travel Vouchers

Form SF-1012, front and back (Link to Image)

Form CA-77 (Link to Image)

FECA BULLETIN NO. 99-26

Issue Date: May 10, 1999

Expiration Date: May 9, 2000

Subject: District Office Use of Nurses Providing Telephonic Services

Background: FECA Bulletin NO. 97-11 provided the initial guidelines for use of Telephonic Case Managers (TCM) in district offices. While these guidelines remain valid, our experience over the last two years and particularly the results of the quality assurance review performed by the National Office staff in 1998 demonstrated the need to revise and clarify certain issues. This bulletin sets forth the revisions to district office procedures for the use of TCMs.

Purpose: This bulletin will provide improved guidelines and procedures for the use of TCMs in the district office.

Reference: Federal (FECA) Procedure Manual Chapters 3-201 and 3- 202; FECA Bulletin 97-11.

Applicability: Regional Directors, FEC District Directors, FEC Staff Nurses and Claims Examiners.

Action:

1. Determining the number of TCMs. The District Offices Staff Nurse will continue to determine the number of nurses necessary to handle those cases subject to telephone intervention. Before TCMs are recruited, the SN needs to determine the number of cases suitable for TCM intervention and thus establish the number of TCMs necessary to handle the case load. (Criteria for case selection is discussed in action item # 4.) District offices must continue to maintain referral and reporting procedures which meet QCM time limits and privacy requirements, and the SN must track and monitor TCM progress.

2. Certification of TCMs. TCMs must be certified by OWCP and their recruitment, selection and certification must be in keeping with the process described in the FECA Procedure Manual Chapter 3-201. Nurses selected for telephonic intervention must sign a Memorandum of Agreement (MOA) unique to telephonic intervention activities (**see Exhibit #1 (Link to Image)**). A nurse cannot perform both face to face and telephonic intervention at the same time. She/he must elect one of the two types of intervention and sign the appropriate MOA. Contract nurses must hold valid licenses in the states where their assigned claimants reside.

3. Establishing TCM work-site. All nurses providing telephonic services must establish their own work sites (e.g. home, office) and cannot perform their routine duties in the district office. They may come into the office as necessary to obtain or drop off documents, etc. While in the office, the nurse may interact with the claims staff, and have access to the telephone and copying machines. They are otherwise responsible for furnishing their own supplies and materials. Data from the TCMs must be added into the Nurse/Rehabilitation Tracking System by FECA or contract staff (Orkand) other than the TCMs. The ability to control and assure accuracy of data input is maintained more effectively if OWCP staff enter this case-specific information.

4. TCM Case Selection, Time Frames and Reporting Format.

a. Case Selection: Telephone intervention can have successful outcomes in cases with widely different diagnoses, length of disability, and/or demographic characteristics. However, because of its total dependence on oral communication at a distance, it may not be appropriate in some instances. Our experience over the last two years (in particular, the National Office quality assurance review conducted on TCM cases) indicates that case selection can enhance results. Based on this review, referrals to TCM should exclude cases involving claimants with recurrences, known multiple claims and/or attending physicians known to provide prolonged care. Additionally, whenever surgery, special nergonomic work accommodations or indications that the return-to-work (RTW) adjustment will be a difficult one either mentally (stress claim) or physically (RTW with special needs such as crutches, splints, casts etc.), TCM intervention needs to cease and referral should be made to a field nurse.

b. Time Frames: To maximize results and to observe QCM time frames, a limit of 60 days should be applied to the TCM intervention activities. If at this point, the return to work has been secured via a completed OWCP–5, or return to work is imminent, the TCM may remain on the case to complete the required sixty day follow-up. In some circumstances, the TCM may accomplish a RTW/modified duty at 30 days into the intervention. In these cases, the TCM may continue to remain on the case in order to achieve either full duty release or at least a

lessening of the job modifications, but is not to exceed the 120 day total time on the case. The CE may allow extensions in special circumstances, such as when there are no available field nurses in the claimant's vicinity or when the TCM possess language or professional skills that are necessary for the successful management of the case. Absent these factors, after 60 days the case needs to be transferred to a Field Nurse who will initiate face-to-face intervention.

Given this 60 day time frame-TCMs are not to be put into INTERRUPT as this status typically lasts at least 2-3 months (seeking second opinion examinations and/or performing surgical procedures) with no assurance that there will be a return-to-work at the end of the interruption phase and only delaying the referral to a FN for face-to-face intervention.

c. Reporting Format: Telephonic nurse case managers need to submit monthly reports identifying "plans of action" and results of contacts with attending physicians and employing agencies. The SN or Claims Examiner (CE) reviewing these reports should be able to judge at a glance what important milestones in the case have been met (RTW date) or missed (no OWCP-5 received from the attending). In addition, when referral to a FN becomes necessary, the TCM must complete a "closure" report which details the factors requiring the transfer for FN intervention. This closure information will not only assist SN/CE in recognizing the need for transfer to a FN but, will help the FN move expeditiously on those areas previously identified by the TCM needing face-to-face intervention. A "sample" TCM reporting format is enclosed for your reference. (**Exhibit #2 (Link to Image**)

5. General Duties and Guidelines for TCM activities.

a. Duties - As detailed in FECA Bulletin No.97-11, TCMs may offer medical guidance and input on cases but cannot perform functions which are the responsibilities of the claims examiners such as: preparing statements of accepted facts or questions for a second opinion or referee physician. Further, the nurse's functions are limited to the individual cases assigned to them for medical management and they are not to perform duties such as scheduling second opinion examinations or handling medical authorizations requests on an office-wide scale. The SN provides general instructions to the TCM in order to accomplish a RTW goal. However, once a case is assigned, the TCM does not receive direct and continuing supervision.

b. Guidelines - TCM performance, like FN performance, is evaluated on case outcomes and the timeliness and quality of services. If these actions are deficient, termination of TCM services should follow the same parameters outlined for FNs in FECA Procedure Manual Chapter 3-202, paragraph 13 –Warning And Termination Procedures.

6. Reimbursement Requirements for TCMs.

a. Yearly Maximum - Each district office has the discretion to set the professional and administrative reimbursement rate for their TCMs. However, each nurses providing the telephonic case management cannot exceed a yearly maximum of $50,000. Any TCM who reaches this amount cannot be assigned any more cases for the balance of the year. This cumulative reimbursement excludes all long distance phone and fax charges. To clearly separate these costs from the $50,000 maximum, they should be billed only under the NCPTC. Code.

b. Documentation -TCM activities require documentation in the form of monthly reports. Reports are to be accompanied by bills submitted on the HCFA-1500 form. Unique codes have been developed for use by TCMs not only to identify specific costs and services for this intervention but, to also allow their bills to be processed without being subjected to the prior-authorization edits.

c. Coding –

NCA00 - Telephonic nurse intervention, administrative - increments of time less than 1 hr.;

NCA01 - Telephonic nurse intervention, administrative - 1 hr. increments of time;

NCP00 - Telephonic nurse intervention, professional services increments of time less than 1 hr.;

NCP01 - Telephonic nurse intervention, professional services 1 hr. increments of time.

A review of the ongoing charges of each TCM may be monitored through the use of the monthly NI-7 (B & C) reports.

Disposition: Retain until the expiration date or until superseded.

Sheila Williams
Acting Director for
Federal Employees' Compensation

Attachments

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

FECA BULLETIN NO. 99-27

Issue Date: June 18, 1999

Expiration Date: June 17, 2000

Subject: Bill Pay/BPS - Authorization of High Dollar Medical Bills

Background: Recent OIG audit findings indicate there is a need for documenting the supervisory authorization of payment on medical bills beyond established dollar limits. Although the current FECA Procedures require that bills above established dollar limits (based on the type of provider involved) be authorized by a higher level person, the recurrence of duplicate payments in extremely high dollar amounts suggests the need to document that those procedures are being followed. The ability of OWCP to document the review and authorization of high cost medical bills at the supervisory level (GS-13 and above) will enable the Office to ensure the accountability for payments from the Compensation Fund, and to decrease the number of errors from duplicate payments of large amounts.

Reference: FECA Bulletin 98-5.

Purpose: To provide additional guidance regarding the authorization of medical bills beyond $50,000.00 and to emphasize the importance of accountability with clear documentation that the responsible resolver has taken appropriate action in high dollar medical bill payments.

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

Actions:

1. If the district office currently has satisfactory procedures in place for authorizing bills under $50,000.00, they should be continued. The effectiveness of such procedures will continue to be monitored biannually in the accountability review process and annually during the OIG's Consolidated Financial Statement Audit.

2. Regarding bills of $50,000 and above, each district office will devise its own new procedures for ensuring that they are reviewed and authorized by an individual at the appropriate level. In these cases, the district offices will select one of two options. The option chosen by each district office will be operative for all bills at and above the stated amount in the respective

office. That is, bills of $50,000 and above will all be handled in a uniform manner based on the option chosen. The two available options are as follows:

(a) The higher level bill authorizer would maintain a personal log of all bills authorized. The log would include all the information necessary to identify the case, the bill, the provider, and the amount authorized.

(b) The second option would involve having the higher level authorizer retain paper copies of the actual bills containing the authorizing official's initials.

In either of the above described options, the auditors would be able to seek out the persons whose initials are in the BPS as having authorized any particular bill for payment. With either method, the auditor would verify that the person whose initials are in the BPS history actually approved that bill for payment.

3. Once the method of documenting the authorization of high cost medical bills has been chosen by the district office, the National Office should be advised via e-mail to Sheila M. Williams, copy to Ken Siglin. The district office plans should be selected and operative within 30 days of the issuance of this FECA Bulletin.

Disposition: Retain until incorporated in the Federal (FECA) Procedure Manual Part 2 Chapter 810.

SHEILA M. WILLIAMS
Acting Director for
Federal Employees' Compensation

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

FECA BULLETIN NO. 99-28

Issue Date: August 30, 1999

Expiration Date: August 29, 2000

Subject: Return to Work--Temporary Assignments During Recovery

Background: Among the factors which the Office of Workers' Compensation Programs (OWCP) considers in assessing whether a job offered to an injured employee is suitable is whether the kind of appointment (permanent, term, or temporary) is at least equivalent to that of the job held on the date of injury.

If the two appointments are not equivalent, then the offered job cannot be found suitable. For instance, if the employee's date of injury job was permanent, OWCP may not find a temporary or term job suitable. Likewise, a term employee must be offered at least a term appointment; a temporary appointment would not be suitable.

This policy is intended to apply to offers of employment which will lead to ratings for loss of wage-earning capacity (LWEC). However, the policy has recently been cited with respect to offers of short-term work made to employees who are still recovering from their injuries and who may be able to perform light duty but who have not reached a level of recovery sufficient to consider rating for LWEC.

A distinction must be made between a position which is temporary, according to the rules promulgated by the Office of Personnel Management, and an assignment which is temporary, and which is made in recognition that a partially disabled employee is able to perform some work during the period of his or her recovery.

An employee who is undergoing vocational rehabilitation efforts at the direction of OWCP may be required to accept an offer of work within his or her limitations while recuperating from a work-related injury, even if that work represents a temporary assignment and the employee has permanent appointment status. Failure to accept such an assignment may be considered failure or refusal to participate in vocational rehabilitation efforts, and such a failure may be sanctioned on that basis.

However, it remains true that a permanent employee may not be rated for LWEC purposes based

on a temporary or term position, nor may his or her refusal to accept such an assignment be sanctioned under 5 U.S.C. 8106(c).

Purpose: To provide guidance with respect to short-term job offers made to employees who are in the early stages of recovery from work-related injuries.

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

Reference: 5 U.S.C. 8106(c) and 8113(b); 20 CFR 10.519(b) and (c); Federal (FECA) Procedure Manual Chapter 2-813.11, 2-814.4 and 2-814.7

Actions:

1. Where an employee is undergoing OWCP-directed vocational rehabilitation efforts, either with a registered nurse or a vocational rehabilitation counselor, an employer may offer the employee a temporary assignment pending further recovery from the work-related injury.

2. An employer who takes such an action should notify OWCP of the nature of the offered position and whether its rate of pay is the same as or less than that of the date-of-injury job.

3. For an employee who accepts such an assignment, compensation will be paid on an actual-earnings basis pending further recovery.

4. OWCP will consider an employee who refuses to accept such an assignment as failing or refusing to undergo a vocational rehabilitation effort when so directed. As stated in the program's regulations at 20 CFR § 10.519(b):

> Where a suitable job has not been identified, because the failure or refusal occurred in the early but necessary stages of a vocational rehabilitation effort...OWCP cannot determine what would have been the employee's wage-earning capacity.

5. Therefore, in accordance with the procedures outlined in the Federal (FECA) Procedure Manual, Chapter 2-813.11, the Claims Examiner (CE) should warn the employee that, absent evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity.

6. In addition to any evidence which the employee may present in response to such a warning, the Claims Examiner must consider the rate of pay of the offered assignment. A rate of pay less than that of the date of injury job, due either to a change in differential pay or to provision of different work altogether, will constitute "evidence to the contrary".

7. If the claimant does not resume cooperation with vocational rehabilitation efforts, his or her compensation should be reduced, either to zero if no evidence to the contrary has been presented, or based on the rate of pay of the job assignment if evidence to the contrary has been presented. As stated in 20 CFR § 10.519(c), "The reduction will remain in effect until such time as the employee acts in good faith to comply with the direction of OWCP."

8. However, it is not proper to rate for LWEC an employee who accepts such a temporary assignment unless the terms of the job are modified so that the original and new appointments are equivalent. For instance, a temporary assignment which meets a permanent employee's work limitations may not be used for a rating, but if the employer makes the same job permanent, and the job is classified in accordance with 20 CFR § 10.509(b), such a job would be considered proper for LWEC purposes.

Disposition: Retain until the indicated expiration date.

SHEILA M. WILLIAMS
Acting 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. 99-29

Issue Date: August 5, 1999

Expiration Date: August 4, 2000

Subject: Bill Payment/BPS - Correct Coding Initiative, Part A.

Background: Many medical bill processing systems include edits that are designed to detect certain types of coding error and abuse. While the DFEC bill processing system (BPS) already includes some of these edits, there are additional elements that are being added to enhance the system, under a Correct Coding Initiative (CCI). CCI is modeled on a system implemented by Medicare in 1996. Staff has already been hired in the National Office to implement CCI, and additional staff in each district office will be hired shortly.

CCI implementation will consist of two major parts. Part A includes editing for age-specific procedures, sex-specific procedures, unlisted procedures, excluded procedures, and modifier validity. Parts B and C, to be implemented in the future, will include editing for mutually exclusive procedures, comprehensive/component procedures, add-on codes, and global periods. Part A is in effect with the issuance of this Bulletin, or shortly thereafter. Information concerning Parts B and C will be provided at a later date.

Reference: Federal (FECA) Procedure Manual Chapters 5-0203 and 5-0204.

Purpose: To communicate procedures for processing bills under the CCI, Part A.

Applicability: Claims Examining, Bill Processing and CCI personnel.

Actions:

1. The CCI edits are applicable only to certain CPT-4 codes.

2. Four new BILL552 edits have been developed for CCI Part A. These include an edit for age-specific procedures (361), female-only procedures (362), male-only procedures (363), and unlisted procedures (364). Detailed edit sheets for these four new edits are being sent under separate cover, along with the revised condensed BPS edits, and the revised EOB listing.

3. Attachment 1 shows age-specific procedures. These procedures are only applicable to

children. Since FECA claimants are not children, these procedures are not payable under the FECA.

4, Attachment 2 shows female-only procedures. Attachment 3 shows male-only procedures.

5. Attachment 4 shows excluded procedures. These are procedures that are not payable for work-related conditions. Excluded procedures are already identified by BILL552 edit 303.

6. Unlisted procedures are found at the ends of CPT code groupings, and usually end in 99. An example would be 20999, "unlisted procedure, musculoskeletal system." These codes are supposed to be used only when another CPT code cannot be used appropriately, and often require a medical report to support use of the unlisted code.

7. When errors 361, 362, and 363 are assigned, denial is automatic, and the edit failure cannot be overridden. Error 364 failure results in a suspension, which must be manually reviewed and may be overridden if appropriate.

8, Invalid modifiers are already identified by BILL552 edit 318.

9. All billing issues with respect to these edit failures, including resolution of these edit failures, should be referred to the CCI specialist. The CCI specialist is not responsible for other edit failures that may occur on a bill. Other edit failures on the bill should, in general, be resolved before the bill is referred to the CCI specialist. If problems arise with respect to these edits prior to the CCI specialist being on board, contact either Yvette Sanders (202-693-0886) or Cheryl Bullock (202-693-1027) at the National Office. Edit 364 will not be activated until after the CCI specialists have been hired and trained.

Training on this Bulletin should be completed within 30 days of the issuance of this bulletin.

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

SHEILA M. WILLIAMS
Acting Director for
Federal Employees' Compensation

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

Attachment 1

AGE-SPECIFIC PROCEDURE CODES
24640
25450
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99440

Attachment 2

SEX-SPECIFIC PROCEDURE CODES - FEMALE
00842
00846
00850
00855
00857
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00952
00955
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19325
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Attachment 3

SEX SPECIFIC PROCEDURE CODES - MALE
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Attachment 4

EXCLUDED PROCEDURE CODES

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FECA BULLETIN NO. 99-30

Issue Date: August 30, 1999

Expiration Date: August 29, 2000

Subject: Third Party--Claims from Certain Census Workers

Background: To conduct the Decennial Census and other kinds of census surveys, the Bureau of the Census employs enumerators and field representatives who visit private properties and

interview residents of the properties to gather statistical data.

Section 5 U.S.C. 8131(a) states in part that:

> If an injury or death for which compensation is payable...is caused under circumstances creating a legal liability on a person other than the United States to pay damages, the Secretary of Labor may require the beneficiary to-- (1) assign to the United States any right of action he may have...; or (2) prosecute the action in his own name.

If the beneficiary does not do so, he or she is not entitled to benefits under the Federal Employees' Compensation Act.

However, 13 U.S.C. 9(a)(2) prohibits employees of the Bureau of the Census from releasing or allowing "any publication whereby the data furnished by any particular establishment or individual under this title can be identified...." Furthermore, under 13 U.S.C. 214, anyone who releases information protected by 13 U.S.C. 9 "shall be fined not more than $5,000 or imprisoned not more than five years, or both".

Given these provisions of the law, an enumerator or field representative injured while on private property for the purpose of gathering data through an interview with a resident would either have to breach confidentiality, thus risking discipline by the Bureau of the Census and possible prosecution, or lose his or her compensation benefits.

It has therefore been determined that, except where the injury is the result of a deliberate act by the resident, OWCP claims staff should not pursue the third party aspect of a claim for injury or death filed by an enumerator or field representative of the Bureau of the Census.

Reference: 5 U.S.C. 8131(a); 13 U.S.C. 9(a)(2); 13 U.S.C. 214; and Federal (FECA) Procedure Manual Chapter 2-1100

Applicability: Supervisors, Claims Examiners, and Technical Assistants

Action:

1. For cases where an enumerator or field representative is injured while on private property for the purpose of interviewing a resident, the National Office has advised the Bureau of the Census to answer "no" to the question on Form CA-1 which asks whether the injury was caused by a third party. Doing so will allow short form closure if the claim is otherwise eligible for this action, and it will ensure that the case is coded properly for third party tracking purposes.

2. Except as stated in item 3 below, the RCE should not send Form CA-1045 to an enumerator or field representative who is injured while on private property for the purpose of interviewing a resident. Also, the RCE should not refer the case to the designated third party Claims Examiner (DCE).

3. Only if the Bureau of the Census has determined that a deliberate act of a resident caused the injury should the RCE send a CA-1045 and refer the case to the DCE. If it appears to the RCE that a deliberate act of a resident was the proximate cause of the injury, illness or death, and the Bureau of the Census has not made such a determination, the RCE should contact the Bureau of the Census for clarification before taking any third party action.

4. Claims staff should continue to take third party actions on any claim filed by an enumerator or field representative which indicates a potential third party liability due to other activities within performance of duty. For instance, an enumerator traveling from one interview site to another may be involved in an automobile accident on a public street. Here, the provisions of 13 U.S.C. 9 and 13 U.S.C. 214 would not apply, and it would be proper to pursue the third party aspect of the claim.

Disposition: Retain until the indicated expiration date.

SHEILA M. WILLIAMS
Director for
Federal Employees' Compensation

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

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

FECA BULLETIN NO. 99-31

Issue Date: September 27, 1999

Expiration Date: September 26, 2000

Subject: Bill Pay/BPS - Data Entry of Inpatient Hospital Bills

Background: Effective January 4, 1999, a fee schedule for inpatient hospital bills was implemented. Because of the data entry requirements for the new fee schedule, special software was used to data enter inpatient hospital bills. Initially, data entry was performed only in the National Office. During the months of March and April, each district office was trained in the use of the special software, and began performing data entry of their own inpatient hospital bills.

In the months that have followed, the volume of inpatient hospital bills has been much lower than what had been expected, based upon previous years' volume of inpatient bills. In addition, district offices have experienced numerous difficulties in performing the data entry of these bills. The costs associated with maintaining the special software at each site have been considerable.

Effective September 27, 1999, district offices will no longer perform data entry of most inpatient hospital bills. Instead, these bills will be mailed to the National office for data entry, after which the bills will be processed and loaded into the district office systems.

Reference: FECA Bulletin 99-21, "Modifications to Inpatient Hospital Bill Procedures," issued January 4, 1999.

Purpose: To communicate revised procedures for data entry of inpatient hospital bills.

Applicability: All Personnel in the District Offices and National Office.

Action:

1. The District Offices will take the following actions with respect to inpatient hospital bills:

a. Separate inpatient hospital bills from outpatient hospital bills. Hospital bills generally are submitted on form UB-92, although a few other types of providers also use the forms. Only hospital bills which meet the following parameters should be identified as "inpatient" for purposes of keying into the special software:

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

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

b. Screen the inpatient bill for the presence of a six-character provider Medicare number, usually found in form locator 51. Medicare numbers are usually all numeric, but may also contain one alpha character. If the Medicare number is not on the bill, the bill should be returned to the hospital with an explanation and a request that the number be provided.

c. Make sure that the bill contains a valid case file/claimant name by performing a case or name query. If the case file number is invalid, determine the correct case file number, write it on the bill in form locator 60, and cross out the invalid case file number.

d. Place the bills that pass screening as described in items a through c above in a batch. Arrange the bills in alphabetical order by the claimant's last name.

e. Complete a batch cover sheet, and write the batch ID and bill ID on each bill in form locator 61. The first bill in each batch will be bill 001, the second 002, etc. For example, the batch and bill ID for the first bill in batch GH2822 should be written as GH2822.001. Please note that certain characters are very difficult to discern from each other, such as 1 and I, 0 and O. It is preferred that these characters not be used in the batch IDs, but if they are used, they should be distinguishable.

f. Image the batch. Follow quality control procedures to ensure that the batch has been scanned and is viewable.

g. Mail the original batch(es) to the National Office via overnight mail:

U.S. Department of Labor
ESA, OWCP
200 Constitution Ave., NW
Rm. S-3229, Attn: Yvette Sanders
Washington, D.C. 20210

h. Send e-mail to Yvette Sanders (ysanders@fenix2.dol-esa.gov) in the National Office regarding the batches sent, stating:

1) The number of batches sent;
2) The bill IDs for the batches sent; and

3) The number of bills in each batch.

Inpatient bill batches should be consolidated so that only one or two e-mails are sent to Ms. Sanders in any given week.

2. The National Office will take the following actions:

a. Receive the paper bills from the district offices.

b. Review the bills to ensure that they are appropriate for keying into the special software. Any bills that are not appropriate for such data entry will be returned to the district office with an explanation and instructions for further processing.

c. Compare the hospital name, address, tax identification number, and Medicare number with those found on the National Office hospital provider file, and make any corrections needed.

d. Data enter the bills into the special software.

e. Verify the accuracy of the data entry.

f. Transmit the bills to the hospital clearinghouse.

g. Respond to the e-mail from the district office, providing the date the bills were transmitted to the clearinghouse.

3. The remainder of the inpatient bill processing will remain as it currently exists, namely: the clearinghouse will forward the bills for grouping and pricing; National office will associate a provider address with each bill, and transmit the bills to the appropriate district offices; the bills will be loaded into the FECS bill processing tables and edited by BILL552; the bills will be resolved by the appropriate district office staff.

4. If data entry problems arise with respect to inpatient bills keyed by the National Office, including bills that must be corrected and resubmitted, contact Yvette Sanders. District Offices may now correct errors in bill and batch IDs through the use of BILL515, in the FECS004 menu.

5. The personal computer and phone line that was previously dedicated to inpatient hospital bill data entry should not be used for other purposes until further notice.

6. Training on these procedures should be provided to the appropriate staff as soon as possible.

<u>Disposition</u>: Retain until incorporated in the Federal (FECA) Procedure Manual.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULARS (FC)--INDEX

FC 99-01 Reconsiderations - Correct Appeal Rights (10/98B)

FC 99-02 Dual Benefits - FERS COLA (11/98B)

FC 99-03 Loss of Wage Eraning Capacity - USPS and Reassignment to Part Time Flexible Positions (11/98B)

FC 99-04 New Regulations Governing Claims under the FECA (01/99A)

FC 99-05 Selected ECAB Decisions for April - June, 1997 (01/99B)

FC 99-06 Selected ECAB Decisions for July - September, 1997 (01/99B)

FC 99-07 Code changes for the Departments of the Air Force, Army, Defense, Transportation, Treasury, and Veterans Affairs, and the U.S. Postal Service and the Federal Judiciary, Case Management Users' Manual, Appendix 4-7 (01/99A)

FC 99-08 Current Interest Rates for Prompt Payment Bills and Debt Collection (02/99A)

Attachment 1: Prompt Payment Interest Rates
Attachment 2: DMS Interest Rates

FC 99-09 Selected ECAB Decisions for January-March, 1998 (04/99A)

FC 99-10 Seclected ECAB Decisions for April-June, 1998 (04/99A)

FC 99-11 Selected ECAB Decisions for July-September, 1998 (04/99B)

FC 99-12 Revised CA-7 (04/99B)

FC 99-13 Current Interest Rates for Prompt Payment Bills and Debt Collection (08/99A)
Attachments: Prompt Pay and DMS Interest Rates

FC 99-14 Loss of Wage Earning Capacity--Actual Earnings from Temporary Positions (08/99B)

FC 99-15 Selected ECAB Decisions for October - December 1998 (09/99A)

FC 99-16 Revised Form CA-1 (09/99A)

FC 99-17 Selected ECAB Decisions for January - March, 1999 (09/99A)

FECA CIRCULARS--TEXT

FECA CIRCULAR NO. 99-01 **October 12, 1998**

SUBJECT: Reconsiderations - Correct Appeal Rights

It has come to our attention that full appeal rights are being issued with a certain number of merit reconsideration decisions.

As stated in FECA Procedure Manual Chapter 2-1602.8c, a claimant who receives a merit decision on reconsideration is entitled to review by the Employees' Compensation Appeals Board or to another reconsideration, but not to a hearing. When the right to a hearing is included in the description of appeal rights, and the claimant requests a hearing, the Branch of Hearings and Review must honor the request even if the "right" was included in error. This results in an additional and unwarranted workload for the Branch of Hearings and Review.

Senior Claims Examiners are reminded to ensure that proper appeal rights are appended to reconsideration decisions.

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. 99-02 **November 18, 1998**

SUBJECT: DUAL BENEFITS – FERS COLA

Effective December 1, 1998, Social Security Benefits will increase by 1.3%. 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 6, 1998. No adjustment will be made for the period December 1, 1998 through December 5, 1998.

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, 1998.

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

SSA COLA's are as follows:

Effective December 1, 1998	1.3%
Effective December 1, 1997	2.1%
Effective December 1, 1996	2.9%
Effective December 1, 1995	2.6%
Effective December 1, 1994	2.8%

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 99-03 **Novmember 20, 1998**

SUBJECT: LOSS OF WAGE EARNING CAPACITY – USPS AND REASSIGNMENT TO PART TIME FLEXIBLE POSITIONS

The purpose of this Circular is to acquaint claims staff with the Snow Arbitration Decision and the impact of this decision on reassignments within the Postal Service.

Sometimes, the Postal Service, in finding a position for a partially disabled employee, reassigns the injured employee to a position that is in a different craft than the position held when injured. The Snow Arbitration Decision requires the Postal Service, when placing an employee in a different craft, to follow the rules of the receiving craft, so that the placed employee does not adversely impact other current craft employees. Therefore, if there are Part Time Flexible (PTF) employees in the receiving craft, the employee must be placed in a PTF job.

The Procedure Manual at 2-814.7,a(1) states that a part-time job is not suitable employment for an employee who was full time at the time of the injury.

The Postal Service guarantees the reassigned employee 40 hours of work per week. The reassignment is therefore viewed by OWCP as a full-time position.

Also, when placing an injured worker in a PTF position in another craft, the Postal Service converts the employee at a saved rate that guarantees the employee's salary as of the date of injury. The hourly rate of pay is computed by dividing the annual salary by 2000, rather the 2080 used for full-time employees. The 80 hour difference represents the 10 Federal holidays. The employee makes more per hour to accommodate the missing holiday pay. If, in fact, the employee then works a holiday, they are paid again for the holiday. Therefore, there is no loss of wage earning capacity associated with the reassignment.

In claims where the Postal Service has reassigned a partially disabled employee, who had full time career status on the date of injury, to a position that is classified as Part Time Flexible, the claims examiner must look at the terms of the reassignment to determine whether the reassignment represents suitable employment. If the position guarantees 40 hours of work per week, it is considered a full-time position, even though it is categorized as PTF administratively. If it meets the physical requirements of the employee, it is a suitable job. If the conversion to PTF is at a saved rate of pay, there is no Loss of Wage Earning Capacity. A zero LWEC decision should be issued in these cases based upon the reassignment.

Complaints of loss of advanced annual leave, seniority, bidding rights and other privileges are not covered by the FECA and are not relevant to a decision on LWEC. These are labor management issues that should be resolved in that arena.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 99-04 **December 24, 1998**

SUBJECT: New Regulations Governing Claims under the FECA

On November 25, new regulations for claims under the FECA were published in the *Federal Register*. They take effect on January 4, 1999. Copies have been shipped to each district office. They will also be available in FolioVIEWS on January 4, and from the program's home page very soon thereafter.

The regulations have been completely rewritten, so all claims staff should familiarize themselves with the new organization and contents. The reasons for the substantive changes are addressed in the Preamble to the regulations themselves. A series of FECA bulletins addressing the various changes will be issued shortly.

Citations to the regulations in letters in the Forms Correspondence and Letter Generator systems are being updated to reflect the new regulations, and these changes should also be in place by January 4. While the printed version of Form CA-1032 is being revised, copies will not be available until after January 4. Copies of Form CA-1032 citing § 10.125 will be legally unenforceable after that date, and they should be discarded.

Publications CA-810, "Injury Compensation for Federal Employees," and CA-550, "Federal Injury Compensation", are also being revised.

A brief description of the major changes is as follows:

Subpart A--General Provisions

1. A description of "recurrence of medical condition" now appears (§ 10.5).

2. A new provision requires employing agencies to treat records collected in claims under the FECA, including copies of records maintained by the employing agency, as official records of OWCP (§ 10.10, § 10.11, § 10.12).

3. Provisions addressing suspension of benefits during incarceration and termination of benefits for conviction of fraud against the program now appear(§ 10.17, § 10.18).

Subpart B--Filing Notices and Claims; Submitting Evidence

1. The employer may file a notice of injury, occupational disease, or death if the employee or survivor cannot do so (§ 10.100, § 10.101, § 10.105).

2. A claim may be withdrawn before adjudication (§ 10.100, § 10.101, § 10.105).

Subpart C--Continuation of Pay

1. Use of COP must begin within 45 days after the injury. For a recurrence, use of any remaining days must begin within 45 days of the time when the employee first returned to work after the initial period of disability (§ 10.205, § 10.207).

2. The employer may terminate COP when a preliminary notice of a disciplinary action has been issued (§ 10.222).

3. The employer may obtain medical evidence only in writing, not by telephone, during the COP period (and afterward as well)
(§ 10.506).

4. On account of separate legislation, Sunday premium pay for time not actually worked may no longer be included in COP.

Subpart D--Medical and Related Benefits

1. The employer need not issue a Form CA-16 more than one week after injury has occurred (§ 10.300). This statement has appeared in Publication CA-810, but it has not been part of the regulations previously.

2. New guidance is provided concerning medical testing for exposures to workplace hazards (§ 10.303).

3. Attendants' allowances will now be paid as medical expenses, up to $1500 per month. This method of payment will allow for better monitoring of services and accounting of costs (§ 10.314).

4. Misbehavior of a representative is considered misbehavior of a claimant, for purposes of determining whether a medical examination has been obstructed (§ 10.323).

5. OWCP may (but will not always) require an original signature on a medical report (§ 10.330).

6. Form CA-17 is to be used only for traumatic injuries, since the form is not designed for use with occupational disease cases (§ 10.331).

7. OWCP will not always require submittal of an x-ray or the report of x-ray to support a claim for subluxation of the spine (§ 10.331).

8. OWCP uses the AMA Guides for determining schedule awards; the kinds of measurements usually used to make such determinations are described (§ 10.333).

9. The claimant may be reimbursed if a provider does not refund the balance of a partially paid bill to the claimant (§ 10.337).

Subpart E--Compensation and Related Benefits

1. Maximum and minimum compensation rates do not include locality pay (§ 10.406).
2. A new section addresses concurrent receipt of compensation and separation or severance pay (§ 10.421).

3. A new section addresses elections between FECA and FERS (reduction of FECA benefits to reflect SSA entitlement due to federal service) (§ 10.421).

4. The detailed material concerning representative payees has been condensed to one paragraph. Specific procedures will be added to the Procedure Manual.

5. Although the proposed regulations excluded any mention of leave buy-back, a brief paragraph which recognizes this kind of transaction has been added to the final rule (§ 10.425).

6. Language addressing how claimants are put on notice of an overpayment has been made more specific. The existence of EFT payments is also recognized (§ 10.430).

7. The manner in which OWCP applies the "against equity and good conscience" test for waiver of an overpayment is revised to correct an inadvertent error in the 1987 regulations (§ 10.437).

Subpart F--Continuing Benefits

1. A new section addresses how OWCP evaluates medical evidence (§ 10.502).

2. The new rule recognizes that the Office of Personnel Management, not OWCP, administers 5 U.S.C. 8151 (§ 10.505).

3. A new provision allows employers to contact employees at reasonable intervals to request medical reports addressing return to work (§ 10.506).

4. A new provision addresses reductions-in-force (RIFs) of employees performing light-duty work. Loss of a job in this way is not considered a recurrence of disability (§ 10.509).

5. A job must be classified for a formal rating to be done
(§ 10.509).

6. OWCP nurse services are now included in the definition of vocational rehabilitation services, and sanctions may be applied for refusal to cooperate (§ 10.518).

8. A new section addresses volunteer activities (§ 10.526).

9. Computer matching may be used to verify reports of earnings (§ 10.527).

Subpart G--Appeals Process

1. The claimant cannot request review on the Director's own motion (§ 10.610).
2. Subpoenas are only to be issued in connection with a hearing, and only as a last resort (§ 10.619).

3. A Hearing Representative may deny a claimant's request that an employing agency representative testify, if the testimony would not be relevant or the employing agency representative does not have the information in question (§ 10.621).

4. Postponement of an oral hearing must be requested before the hearing is scheduled; otherwise, it may be requested only for non-elective hospitalization or death of immediate family member (§ 10.622).

Subpart H--Special Provisions

1. Federal employees may serve as representatives only under certain limited circumstances (§ 10.701).

2. The standards for review of representatives' fees have been streamlined. Where a claimant does not dispute the amount of the fee, OWCP will deem it approved (§ 10.703).

3. The rules for third-party claims more fully interpret and clarify the duties of FECA claimants

and their counsel pursuant to sections 8131 and 8132 of the FECA (§ 10.704 to § 10.719).

Subpart I--Information for Medical Providers

1. OWCP's medical fee schedule has been expanded to include pharmacy and inpatient hospital bills (§ 10.809, § 10.810).

After you have received and studied the various bulletins addressing these changes in more detail, you may have further questions. They should be referred to the National Office through a manager or supervisor in your office.

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. 99-05 **January 6, 1999**

SUBJECT: SELECTED ECAB DECISIONS FOR APRIL - JUNE, 1997

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

Several decisions which deal with performance of duty/compensable employment factors are included. Four decisions which address refusal/abandonment of suitable employment are also summarized. Additional topics included in the summaries are schedule awards and impartial examiners.

Two decisions are included in their entirety. The first, Kenneth H. Wiggins, Docket No. 95-1581, issued June 5, 1997, deals with recurrence of disability claimed after a loss of wage-earning capacity determination had been made. The second, Amit Mashall, Docket No. 95-1224, issued April 28, 1997, addresses termination of compensation on the basis of "prophylactic restrictions."

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)

IMPARTIAL EXAMINATIONS - BOARD CERTIFICATION

Charles M. David, Docket No. 95-1239, Issued June 12, 1997

In this claim, a conflict of opinion was found to exist between the claimant's treating physician, a Board-certified internist, and a second opinion physician, a Board-certified orthopedic surgeon, concerning whether the claimant continued to suffer from a disabling knee condition. To resolve the conflict, the claimant was referred to a physician who was not Board-certified for an impartial examination. The Office found that this impartial physician's report constituted the weight of the medical evidence and terminated compensation. The Office's decision was affirmed by a hearing representative, who also found that the impartial examiner's opinion was entitled to special weight.

The Board found that the office had not met its burden of proof to terminate benefits. They quoted Chapter 3.500.4(b) of the Federal (FECA) Procedure Manual, wherein it is stated, "The services of all available and qualified Board-certified specialists will be used as far as possible to eliminate any inference of bias or partiality." Because the selected impartial physician was not Board-certified, the Board found that he could not be considered as an impartial specialist whose report was entitled to special weight, and the Office's decisions dated October 19, 1993 and September 20, 1994 were reversed.

PERFORMANCE OF DUTY - FACTORS OF EMPLOYMENT

Joseph F. Coyle, Docket No. 95-1465, Issued April 18, 1997
Ellis Jones, Jr., Docket No. 95-1810, Issued June 13, 1997
Ronald B. Sheckler, Docket No. 95-1144, Issued June 25, 1997
Ruby B. Kendall, Docket No. 95-1991, Issued June 2, 1997
Diane Smith, Docket No, 95-2039, Issued May 23, 1997
Rosemary M. Wasem, Docket No. 95-1420, Issued May 21, 1997
Gregory S. Lammers, Docket No. 95-1482, Issued June 3, 1997
Gareth D. Allen, Docket No. 95-1184, Issued April 15, 1997

A number of interesting decisions were issued by the Board during this quarter which concerned emotional conditions allegedly due to various compensable and non-compensable factors of employment.

In Coyle, the claimant, a letter-sorting machine clerk, attributed his "nervousness, muscle spasms, tension headaches, nausea, diarrhea, confusion, disorientation, sleeplessness and depression" to the high noise levels he encountered while working. He stated that the music played on the public address system was loud, that individual workers also played their personal radios loudly at times, and that they also engaged in loud yelling, singing, and noise making. He complained about the noise to managers on several occasions. Sometimes corrective actions were taken, and other times they were not. The Office denied the claim after requesting additional medical and factual information, on the basis that the claimant did not establish that he had sustained an injury as alleged. The claimant subsequently requested reconsideration and submitted a more detailed statement of the employment factors which he believed caused his condition. Modification of the prior decision was denied. The claimant again requested reconsideration and submitted a medical report from a psychologist, which supported the claim with some rationale. Modification of the prior decisions was again denied. The accompanying memorandum stated that the Office accepted as factual that the claimant's supervisor took appropriate steps to control the noise from the radio and coworkers, and that the incidents therefore did not occur in the performance of duty.

The Board found that the case was not in posture for decision. They stated that everyday noise encountered as part of a claimant's regular and assigned duties would constitute a compensable employment factor. The claimant submitted evidence to support that he was exposed to noise during his employment, which was supported by a medical officer having offered him noise-reduction devices, and by his supervisor having agreed that noise in the workplace was a problem. The case was remanded to the district office for preparation of a statement of accepted facts and referral to an appropriate medical specialist.

In Jones, the claimant alleged that he developed stress when he was transferred from his job as a safety specialist to a new job as a mail processing supervisor. He stated that his working hours changed, he did not know how to adjust to his new life, he was being forced to retire, he lacked the experience to perform the duties of the new job, and he received inadequate training for the new job. He submitted medical evidence from a Board-certified specialist that detailed the recent job transfers, and stated that without sufficient notice, he had been put in a job he could not perform adequately, which had led to diminished confidence, fear, insecurity, suspicion, and paranoia. The Office denied the claim on the basis that the evidence failed to establish that an injury was sustained. They found that some [compensable] employment factors occurred, without specifying those employment factors, but that a medical condition resulting from those factors was not demonstrated by the evidence of record.

The Board remanded the case for creation of a statement of accepted facts to include delineation of compensable and non-compensable employment factors. The attending physician was to be provided with the SOAF and asked to provide an opinion on causal relationship, after which further necessary development was to take place. The Board noted that stress attributed to the change in his work schedule and his inability to perform the new job would be compensable, while stress due to perceived fear of losing his job or being forced into retirement, or from the transfer itself (absent any evidence of error or abuse on the agency's part in making the transfer) would not be compensable. The Office is responsible for making a findings of fact concerning compensable and non-compensable employment factors.

The claimant in Sheckler was an industrial engineer who claimed that his depression was due to ongoing investigations by the CIA and the FBI, as well as other work factors. The Office denied the claim on the basis that he did not establish that he sustained an emotional condition in the performance of duty. A hearing representative affirmed the Office's decision, finding that the claimant failed to establish any compensable factors of employment. The Board remanded the case for the Office to make a findings of fact on all of the alleged factors, write a SOAF, and refer the claimant for examination by an appropriate medical specialist. In evaluating factors of employment, the Board found that the following events were not compensable employment factors: alleged employer harassment due to arrangements having been made for him to meet the man who had previously investigated him (for time and attendance violations) on his first day at a new job (the employer stated the meeting was purely coincidental); alleged employer harassment due to a "spy" having been sent to overhear a private telephone conversation (the employer denied this allegation); poor management at the employing establishment and the claimant's overqualification for his position (these relate to the claimant's frustration at not being permitted to work in a particular environment); a letter of reprimand for putting up union signs and a suspension for statements he made regarding a superior (these involve the administration of personnel matters, and there was no evidence of employer error or abuse); and investigation for time and attendance matters (no evidence of employer error or abuse). They found that investigation of the claimant for alleged computer theft did constitute a compensable

factor of employment, because the claimant's position required him to transport computer hardware and software, and in performing these duties he had twice been stopped by security and had his car searched. The Board also directed the Office to make findings regarding the allegations that the employer did not provide the claimant with the proper licensing for his computer software, adequate software to perform his work, or appropriate manuals for the software, where the evidence of record was contradictory.

In Kendall, the claimant attributed her illness to a coworker's having spread a rumor that she was suffering from a serious medical condition. She overheard this coworker and another coworker talking about her condition on the workroom floor. The Office denied the case, finding that the subject of the alleged harassment was not a result of the day-to-day work activities, a special assignment, or a requirement imposed by the employment, or by the nature of the claimant's work, but rather, was personal in nature, and therefore did not arise in and out of the course of employment. The Board remanded the case for further factual development, stating:

To the extent that disputes and incidents alleged as constituting harassment by coworkers are established as occurring and arising from appellant's performance of his regular duties, these could constitute employment factors. Even if the subject of the alleged harassment is personal in nature rather than work related, this is not dispositive of its connection to work. Even if the alleged harassment arose from a nonwork topic, the Board has held that such matters may be compensable if the employment brought appellant and the coworker together and created the conditions which resulted in the harassment. There is no evidence that appellant and her coworker had any relationship outside of the one at work. Their work brought them together and created the conditions that resulted in the alleged harassment.

In Smith, the claimant alleged stress caused by an incident with a coworker. While she was on break, the coworker who relieved her received a telephone call from her husband, but did not have her paged. When she returned from her break and found out what had happened, she said that in the future, she should be paged when she received a telephone call. The coworker then began to speak loudly and abusively toward her. The Office denied the claim on the basis that the incident did not arise in the performance of duty. The Board remanded the case for creation of a SOAF and development of the medical evidence. They stated that the claimant's description of the incident was supported by statements from two supervisors, and that given the nature of the verbal altercation, the claimant's perception could not be considered self-generated. Although the incident did not bear directly upon the claimant's regular assigned duties, it was not imported into the work due to a relationship outside the workplace, and bore sufficient relationship to the employment to afford coverage.

In contrast to Smith, in Wasem, the claimant also alleged stress due to incidents with coworkers, but with a different outcome. While having a conversation with a coworker, another coworker asked whether it was the first coworker's wife's "time of the month." The claimant asked the

second coworker what he meant by the remark, to which he responded, "don't worry about it, you know what I mean, unless it's your time of the month." The claimant stated that she was humiliated by this remark. Later that day she overheard another coworker arguing with her supervisor and a union steward about whether she should be sent out on the street, and her light duty status. She told her supervisor that she was upset over the comments she had overheard, and both he and the union steward attempted to calm her down. She left work shortly thereafter. The Office denied the claim, finding that with respect to the first incident, the comments directed to her were not made as a threat, as harassment, or in a sexually abusive manner, and that with respect to the second incident, the supervisor took immediate action to control the coworker's profanity and tone of voice, and therefore there were no compensable factors of employment. Modification was denied in a subsequent reconsideration, on the basis that there was no evidence to support the allegation of harassment. The Board affirmed the Office's decisions, finding that neither incident constituted harassment.

In Lammers, the claimant alleged psychological stress due to the employer's requirement that he wear a uniform made of synthetic fibers, which was against his personal health and safety standards. The Office denied the claim on the grounds that the claimant failed to establish an emotional condition in the performance of duty. The Board affirmed the decision. They found that the employer's requirement that he wear a certain uniform did not relate to the duties the claimant was hired to perform, but rather was an administrative or personnel matter, and non-compensable. The claimant did not establish error or abuse on the part of the employer in administering this requirement.

The Allen decision involved rescinding a previous acceptance, based upon new legal argument. The claim was accepted for an adjustment disorder due to the claimant having worked in remote areas as far as 1000 miles from family and friends. A hearing representative rescinded the acceptance, stating that the location of the work, not the work itself caused the disability, and that this represented a desire to work in a particular environment, which is not compensable. The Board found that the Office had not met its burden of proof to rescind the acceptance, and reversed the decision. They agreed that an emotional reaction resulting from a desire to work in a different environment or at a different job does not constitute a personal injury in the performance of duty, and that an emotional reaction due to separation from one's family and friends does not arise in the performance of duty. In this case, however, the claimant also implicated the dormitory situations and the surrounding environment of the remote assignments, which reminded him of his past imprisonment. Assignment to the remote areas itself is not a compensable work factor, but the working conditions of the assignment can be compensable.

REFUSAL/ABANDONMENT OF SUITABLE EMPLOYMENT

Gail Barrick, Docket No. 95-1183, Issued April 18, 1997
Robert W. Velon, Docket No. 95-864, Issued May 16, 1997
Leonard W. Larson, Docket No. 95-1102, Issued May 12,1997
Robert M. O'Donnell, Docket No. 95-795, Issued June 20, 1997

Several decisions by the Board this quarter involved cases in which the Office invoked the provisions of section 8106[c](2) of the FECA, whereby: "A partially disabled employee who€ (2) refuses or neglects to work after suitable work is offered€is not entitled to compensation."

In Barrick, the claim was accepted for bilateral carpal tunnel syndrome. Her physician, a Board-certified orthopedic surgeon, released her for light work following surgery, and approved a light duty position offered by her employer, but said that it would be in the claimant's best interest to work from 6:30 am to 3:00 pm so that she could be driven to work, since she was no longer able to drive herself to work. The employer stated that the job was not available during hours specified by the attending physician. The claimant was notified that the job was found to be suitable, and that she would be reimbursed for round-trip transportation to the job, by either taxi or public transportation. The claimant requested a hearing, and forwarded a medical report from another physician, a Board-certified family practitioner, which stated that the claimant could not tolerate the night shift because it caused a lack of sleep which exacerbated her medical condition. The claimant accepted the job offer on the condition that she could work the day shift. She requested in writing that she be placed in a clerk position which she had formerly held. The request for hearing was denied, as no final decision had been issued. The employer advised the office that the clerk position did not exist for the claimant, and that even if it did, it would involve extensive use of both hands, which was prohibited by her physicians. The claimant was informed that the second physician's note was not sufficient to support that she was unable to perform the offered job. The Office reiterated that the job was suitable, and that reimbursement for transportation would be provided, and was given 15 days to respond to the offer or benefits would be terminated. The claimant responded that her physicians recommended the day shift. The Office terminated benefits, finding that the claimant had refused suitable work. The claimant returned to work for a few days, then filed a new claim for occupational disease and stopped working. The office stated that the new claim would be treated as a recurrence of the old claim. A hearing was requested, and Office's decision was affirmed. The Board also affirmed the office's termination of benefits, finding that the evidence supported the suitability of the job, and that the family physician's opinion that working at night would aggravate the claimant's condition was not sufficiently rationalized. The Board also noted that the new claim had not been adjudicated, and that the Office should undertake development of that claim.

In both Velon and Larson, the Office's termination of benefits for refusing suitable employment

was deemed improper by the Board because the offered positions were temporary. In Velon, the claimant was offered an office clerk position that was being made available through temporary Pipeline funding for a period of one year to eighteen months. The employer stated that their goal would be to place the employee in a permanent position as one became available. The claimant refused the job on the basis that it was temporary, and because he wished to continue vocational rehabilitation. The Office terminated benefits because he refused an offer of suitable work. The Board reversed the decision, finding that the job was unsuitable because it was temporary, and the claimant was a permanent employee at the time of injury. In Larson, the claimant was a respiratory therapist who was offered a temporary position as a medical service administrative support person. The claimant objected to offered job for several reasons, including the fact that it was temporary or unfunded. The agency stated that they would look for a permanent position. The Office found the job suitable, and terminated benefits. The Board found that the job offered was not suitable because it was temporary, and the claimant was a permanent employee.

The situation in O'Donnell is somewhat different, in that it involves termination of benefits for abandonment of suitable work, rather than refusal of suitable employment. The claimant had returned to light-duty work as a clerk on March 2, 1993. The Office determined his loss of wage-earning capacity based upon his earnings as a clerk on May 11, 1993. After that, the claimant filed claims for recurrences of disability for the periods March 21 through April 6, 1993, and May 14, 1993 and continuing. These recurrence claims were denied. In the meanwhile, the claimant was discharged from his employment on September 3, 1993, based upon his absence from work. By decision dated January 11, 1994, the Office terminated his compensation for loss of wage-earning capacity on the basis that he was terminated from his employment for cause, and thus has abandoned suitable work under 5 U.S.C. 8106. The Board found that the Office had properly terminated compensation for wage loss, because the medical evidence did not support that he was unable to perform his light-duty work.

SCHEDULE AWARD - FECA BULLETIN 95-17

Marguerita B. Younger, Docket No. 95-1892, Issued June 10, 1997

In this case, a claim was made for a schedule award due to impairment of the right lower extremity due to a knee condition. The claimant's treating physician stated that the claimant had 40 percent impairment of the knee, based upon the 4th edition of the AMA Guides. An office medical adviser found on March 4, 1995 that the claimant had 12 percent impairment of the knee. He based this figure on AMA Guides, page 78, Table 41, and page 85, Table 64. The Office made an award for 12 percent impairment of the right lower extremity, based upon the office medical adviser's opinion.

The Board remanded the case for further clarification by the office medical adviser. In doing so, they noted that FECA Bulletin 95-17, issued March 23, 1995, stated that certain tables in Chapter 3 of the AMA Guides could not be used together because such usage would lead to "overlapping applications, leading to percentages which greatly overstated the impairment." Tables 41 and 64 were specifically noted as examples of tables that should not be used together. The office medical adviser used those tables in arriving at the 12 percent impairment, and so the Board remanded the case for the office medical adviser to clarify his or her opinion, using the appropriate tables from the Guides.

This decision by the Board is another example of the extreme care that must be taken when assessing the degree of permanent impairment for schedule award purposes. It is noted that in this instance, the office medical adviser's opinion predated the issuance of the relevant FECA Bulletin. However, in any case where the treating physician's percentage of impairment is higher than that of an office reviewer's, an award based upon the lower percentage must be well-supported, inasmuch as there is a high likelihood of an appeal.

SCHEDULE AWARD - PAY RATE WHEN EXPOSURE CONTINUES

Barbara A. Dunnavant, Docket No. 97-58, Issued May 14, 1997

The accepted conditions in this case were aggravation of right and left carpal tunnel syndrome, due to occupational disease. The claimant was disabled for work November 9-24, 1993, when she was off work for a surgical right carpal tunnel release. She used leave for the time she was off from work, but did not claim a leave buy-back.

On June 28, 1994, the claimant's treating physician reported that she had reached maximum medical improvement, and that she had a 20 percent impairment of the right upper extremity. On March 10, 1995, the physician indicated that she had a 15 percent impairment of the left upper extremity. On May 31, 1995, the Office awarded the claimant 20 percent impairment of the right upper extemity and 15 percent impairment of the left upper extremity, and used the claimant's rate of pay as of the date disability began, November 9, 1993, to compute the award. A later Hearings and Review decision increased the award for the left upper extremity to 21 percent, and affirmed the rate of pay used for the calculation of the award.

On appeal, the claimant did not contest the degree of disability awarded, but contended that since she was exposed to work factors until the award was issued, her award should be paid based upon the rate of pay in effect when the award was issued, which would be the "date of injury." The Office maintained that if there is no disability, the pay rate should be calculated using the date of injury, and that if there is a period of disability, the pay rate should be calculated using the rate in effect when disability began, without further consideration of the date of injury rate of pay.

The Board cited Section 8101(4) of the Act, which defines "monthly pay" as:

The monthly pay at the time of injury, or the monthly pay at the time disability begins, or the monthly pay at the time compensable disability recurs, if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater€

In schedule award claims for injuries that occur over a period of time, the Office must determine the date of last exposure to injurious work factors, as well as the date of the medical evaluation which is used to document the degree of permanent impairment. In this case, the claimant continued to be exposed to injurious work factors well after her brief period of disability, as well as up to and after the date when she was examined for schedule award purposes. The Board found that the office erred in using the pay rate in effect when disability began, without considering her additional exposure to injurious work factors after that date. The additional exposure is considered to be part of the injury, and so the "date of injury", for purposes of

determining pay rate, is after the date of disability. The Office did not consider whether the "date of injury" rate of pay was greater than the "date of disability" rate of pay.

With respect to the claimant's position that the rate of pay in effect as of the date the schedule award was issued should be used, the Board found that the "date of injury" would be the date of last exposure prior to the medical evaluation upon which the award was based. If the claimant claims further impairment due to additional exposure after the medical evaluation, a claim for an increased award should be filed.

FECA CIRCULAR NO. 99-06 **January 6, 1999**

SUBJECT: SELECTED ECAB DECISIONS FOR JULY - SEPTEMBER, 1997

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

The subjects addressed include: case doubling, forfeiture of compensation due to failure to report earnings, performance of duty (factors of employment and premises issues), timeliness of reconsideration requests (one in which application of the mailbox rule to the claimant was considered), changes in shift causing recurrence, refusal/abandonment of suitable employment, and timeliness in occupational disease claims.

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)

CASE DOUBLING

James C. Small, Docket No. 95-2716, Issued September 24, 1997

In this case, the claimant alleged that weakness in his legs caused his left knee to buckle. No medical evidence was submitted, and the claim was denied. An oral hearing was conducted, during which the claimant testified that he had a prior injury which was accepted by the office, and for which he received schedule awards for both legs. Medical evidence was also submitted which was supportive of the claim, but not sufficient to meet the claimant's burden of proof. The hearing representative affirmed the Office's denial.

The Board found that given the absence of opposing medical evidence, further development of the record was needed. They remanded the case for doubling with the prior injury case, in accordance with FECA Bulletin No. 97-10, preparation of a statement of accepted facts, and referral to an appropriate Board-certified medical specialist for evaluation.

FORFEITURE OF COMPENSATION - FAILURE TO REPORT EARNINGS

Ruth Moreno Rios, Docket No. 94-1977, Issued July 14, 1997

This case is interesting because of the unusual circumstances involved. Forfeiture of compensation was declared for the period July 7, 1987 through February 1991 due to failure to report earnings. The claimant was found to be at fault in the creation of the resulting overpayment, on the basis that she had knowingly failed to report earnings on forms CA-1032 covering the period of time.

The claimant had worked using two different names and social security numbers. Medical evidence dated July 24, 1990 from her attending Board-certified psychiatrist indicated that the claimant suffered from a form of mental illness in which two personalities were present, each using a different name. The claimant was totally divorced from one personality when she was in the other, and could not remember anything about the other personality.

The Board found that the Office did not establish that the claimant knowingly omitted earnings for a portion of the period that was declared subject to forfeiture. During one of the reporting periods covered by the CA-1032 forms, the claimant was suffering from two personalities, and therefore, a finding that she had "knowingly" omitted earnings could not be made for that period of time. The Board did affirm that periods of time covered by CA-1032 forms signed prior to the July 24, 1990 medical report were subject to forfeiture, since the medical evidence did not specify when the two separate personalities began to manifest themselves.

PERFORMANCE OF DUTY - FACTORS OF EMPLOYMENT

Ana L. Leishman, Docket No. 95-2007, Issued July 3, 1997
Earl D. Smith, Docket No. 95-2749, Issued August 13, 1997

Both of these decisions contain some interesting distinctions between compensable and non-compensable work factors in claims for emotional conditions.

In Leishman, the claimant described several incidents which she claimed caused stress on her job. The district office denied the claim on the basis of failure to establish an injury in the performance of duty. In a subsequent hearing decision, the district office decision was affirmed. The Board, however, reversed the decisions. The work factors cited included the following:

The claimant stated that her supervisor and general supervisor continuously stood close to, observed, and harassed her on a specific date, which led to a verbal altercation with her general supervisor. The supervisor responded that he watched employees at random, and if they were not working, he approached and asked why they were not working. He stated that this had happened with the claimant, and that she argued with him in a loud voice. Several witness statements were submitted which supported the claimant's position that she was unfairly watched and badgered in a hostile manner while attempting to perform her job duties. The Board found that the incident was related to factors of employment.

The claimant posted a newspaper article related to postal killings on the bulletin board, on which some one wrote that she (the claimant) was next. The claimant stated that the postal inspector and supervisor to whom she reported the incident did nothing. However, statements were submitted which reflected that the postal inspector told the supervisor that the claimant just wanted to put the incident on record, and that the supervisor was prepared to give a service talk but was told by the shop steward not to have a service talk because it would alert the individual who wrote the note. The Board found that there was no evidence that the employer erred or acted abusively, and therefore this was not a compensable work factor.

The claimant did not submit support for her allegation of ongoing supervisory observation for extended periods of time, and the Board found that this was not a compensable factor of employment.

The claimant reported a verbal altercation with a co-worker, in which she was called a name but to which she responded in kind. Both she and the co-worker were reprimanded. The Board found that the incident did not arise out of the claimant's regular or specially assigned duties. She had engaged in name calling, and the agency did not err or act abusively in handling the matter, therefore, the incident did not constitute a factor of employment.

Another incident was reported in which a fellow employee made an obscene gesture. There was a history of disagreement between the claimant and this co-worker. This particular incident arose out of a disagreement between them concerning the volume of a communal radio. Since use of the radio was part of the claimant's day to day duties, the Board found that this incident was a factor of employment.
The claimant stated that she was unfairly given a disciplinary action for a nosebleed. The supervisor stated that he called the claimant into his office to discuss other incidents. The Board found that that there was no evidence of employer error or abuse.

Based on the two compensable work factors noted above, and the sufficiency of the medical evidence submitted in support of the claim, the Board remanded the case for the preparation of a statement of accepted facts and referral to an appropriate medical specialist.

In Smith, the claimant was a profoundly deaf city letter carrier who claimed stress due to not receiving timely reasonable accommodations requested under the Americans with Disability Act (ADA). The claimant had been working in another (larger) postal facility, where there were other hearing impaired employees, while there were none at the new facility. The claimant requested the job transfer. During his pre-employment interview, he communicated by using a note pad, and did not request an interpreter. After he began working at the new job, he requested a translator for work-related meetings, a visual fire alarm and other visually-oriented safety devices, and a means of communicating with coworkers and supervisors at work and with the employer while he was on his delivery route. He did not have these items at his former location. He stated that communication had been good at the former location because there was another employee there who knew sign language and could act as an interpreter. It took the employer two months to get a T.D.D. translating machine, and five months for the visual safety devices to be installed, which were installed in places that the claimant could not see. He complained that other clerks would get in front of his face and wave their hands to get his attention. He also claimed that he had not received safety training, had not been trained as a carrier in his new area, or as a clerk, could not call for help when he had truck trouble, advise his employer that he was running late, or attend required meetings because he had no T.D.D. machine or interpreter.

The supervisors responded that the employee had received safety training at his former location, that he received the same clerk training as other individuals, that the T.D.D. machine and other devices had been difficult to obtain because they did not know where to get them, and difficult to install because of the need to hire a contractor and codes. They stated that they were not sure how the claimant wished to be dealt with, since all of his communication was through the shop stewards, rather than directly. They were not aware that people were getting in his face, and prior to his arrival had suggested methods other than touching should be used to get his attention. In a Step 2 Grievance Decision/Settlement, the employer agreed to provide a sign language interpreter at safety meetings, and a portable T.D.D. machine for claimant's use while he was on his route. The employer also stated that when the claimant interviewed for the job, he did not

request special accommodations, and that if he had expressed his needs earlier, they would have accommodated him sooner.

The district office denied the claim, finding that the claimant's condition was not due to compensable employment factors. The Board affirmed the decision. They found that the claimant's job transfer was voluntary, and that he did not make his needs known before he started working on the new job. He had not required special accommodations in the former job. The employer met his needs after they were communicated. The time lag in providing the accommodations was due to the claimant's failure to advise his employer, rather than employer neglect. They stated that the disabling condition arose from not being permitted to work in a particular environment, which is not compensable under the Act, particularly where no advance notice of special needs was given.

PERFORMANCE OF DUTY - ON THE PREMISES

Patrick Dunn, Docket No. 95-2319, Issued July 2, 1997
Diane Bensmiller, Docket No. 95-3108, Issued September 15, 1997

Both of these decisions deal with performance of duty issues.

In Dunn, the claimant requested and was granted leave to consult with his union representative concerning a previous work injury. After speaking with the union representative, he went to the medical records office to obtain copies of the medical reports from his prior injury, for which he had been treated at the employing establishment. He was injured as he left the medical records office. The Office rejected the claim on the basis that fact of injury was not established. Modification of the decision was also denied.

The Board found that the claimant was injured in the performance of duty. "Performance of duty" is interpreted as "arising out of and in the course of employment." When the hours and place of work of an employee are fixed, there is a strong presumption that an employee who is injured on the premises during working hours is in the performance of duty. The claimant was injured while on administrative leave, on the premises, obtaining copies of records for an accepted work-related injury. Copies of the records were needed so that the claimant could obtain treatment for the work-related injury, as the employer was no longer going to provide treatment on the premises. The Board found that this activity was reasonably incidental to his employment, and that he was therefore in the performance of duty.

In Bensmiller, the claimant was injured when she tripped on a metal post while walking in a parking lot which was adjacent to the employing establishment. In response to an Office inquiry, the employer stated that the parking lot was provided for employees, but was not owned, maintained, or controlled by the employer. They stated that parking was provided for all employees because no public transportation was available. Based on this information, the Office rescinded a prior acceptance of the claim, and found that the injury did not occur in the performance of duty, as she was not on the premises.

Following the Office's decision, the claimant sent a letter to the Office, in which she related that on the date of injury, when she attempted to park her car in the employer-owned parking lot, she was blocked due to construction, and was redirected to an adjacent (non-employer) lot. At the time she was injured, she had gone to pick up her lunch and move the car to the regular (employer) parking lot, when she tripped on a protruding post and fell.

The Board found that although the injury did not occur on the employer's premises, the facts of the case brought it into the proximity exception to the premises rule. Under the proximity rule, special circumstances may extend the industrial premises to include hazardous conditions which

are proximately located to the premises. In this case, all employees were provided with parking space on the premises, but due to the special circumstances on the date of injury, the claimant was forced to use an adjacent lot, which contained a hazardous condition, the protruding post. She was in a pay status and was involved in an activity related to her employment (obtaining her lunch and moving her car to the employer's lot) when she was injured. The Board reversed the Office's decision.

RECONSIDERATION - TIMELINESS

Linda F. Anderson, Docket No. 96-2121, Issued September 18, 1997
Maria Puente, Docket No. 95-2240, Issued July 15, 1997
Christine Marcelle, Docket No. 95-2147, Issued August 8, 1997

In Anderson, the Office denied the claimant's request for a schedule award on June 14, 1994. On June 2, 1995, a request for reconsideration and additional medical evidence was received from an attorney, who stated that he represented the claimant. On August 25, 1995, the claimant was informed that the attorney's request for reconsideration was invalid, because there was no written notification from the claimant, appointing the attorney as her representative. On January 9, 1996, the attorney again requested reconsideration, and submitted additional medical evidence, as well as written authorization from the claimant. The claimant contended that the June 2 request for reconsideration was timely, as she did not know that written notice of authorization was required.

On June 5, 1996, the Office found that the request for reconsideration was not timely (not filed within one year), and that the request did not present clear evidence of error.

The Board found that the request for reconsideration was timely, and set aside the Office's denial of reconsideration. They stated, "There is no requirement that the Office actually have the authorization in hand at the time an authorized representative acts on behalf of a claimant. The representative only needs to show that he was authorized at the time such action was undertaken."

The injury was accepted in the Puente case, but the claim of compensation for a specific period of disability was denied on April 7, 1993. In a letter dated May 7, 1993, an appeal was requested. On July 22, 1993, the claimant requested a hearing. She again requested a hearing on October 7, 1993, January 10, 1994, and December 21, 1994. On February 27, 1995, the request for a hearing was denied because it was first requested (on July 22, 1993) more than 30 days after the April 1993 decision. The Office considered the matter further in relation to the issue and denied the request because the issue could be resolved by requesting reconsideration and submitting additional evidence.

A reconsideration of the April 1993 decision was requested on March 20, 1995. The request was denied as untimely and lacking in clear evidence of error.

The Board found that the Office properly denied the request for a hearing, but improperly denied the request for reconsideration as untimely. A hearing had been requested three months after the Office's April 1993 decision. However, the denial of the hearing was not issued until February 27, 1995. The delay in addressing the request for a hearing deprived the claimant of the

opportunity to make a timely request for reconsideration. The case was remanded for a *de novo* decision on the issue of disability for the period that was previously denied, so as to protect the claimant's rights of appeal.

In Marcelle, a claim was filed for stress due to harassment on the job, which was denied on June 1, 1993 for failure to establish injury in the performance of duty. On February 3, 1994, a hearing representative affirmed the district office's decision, and instructed the claimant to direct any request for reconsideration to the district office in Jacksonville, Florida.

In a February 9, 1995 letter, addressed to the Washington, D.C. office and received on March 6, 1995, the claimant stated that she was still waiting for a response to her letter dated April 20, 1994, in which she requested reconsideration. On May 9, 1995, the Office rejected her claim for reconsideration as untimely, and found that it did not establish clear evidence of error. They stated that there was no evidence that the April 20, 1994 letter was actually received in either the Washington, D.C. or Jacksonville offices within one year of the last merit decision in the case, which was issued on February 3, 1994.

The Board considered whether the mailbox rule was applicable in this case. Under this rule, a letter mailed in the ordinary course of business is presumed to have been received. The rule can be applied to communications sent both to and from the Office. However, the rule cannot be invoked unless the sender can show that mail is sent consistently in the course of business. The claimant in this case did not present evidence that she routinely sends correspondence in the course of business, therefore the mailbox rule could not be applied. The Board agreed that the request for reconsideration was not timely, and affirmed the Office's decision.

RECURRENCE - CHANGE IN SHIFT

Fallon Bush, Docket No. 95-2237, Issued July 15, 1997

This claim was accepted for aggravation of arthritis of the left hip, and hip replacement surgery. The office paid compensation for total disability until the claimant returned to light duty work. Shortly after returning to work, the claimant was changed to a daytime shift on the recommendation of his physician, who stated that his arthritic condition was worse later in the day. The claimant continued to work for 20 months, until he was reassigned to an evening shift. He stopped working and filed a claim for total disability, which was denied by the Office.

The Board found that when an employee on light duty stops working, they must show a change in the nature and extent of disability, or a change in the light-duty job requirements. In this instance, the requirements of the job (that he work an evening shift rather than a daytime shift) had changed so that they were no longer within the restrictions specified by his physician. The Board reversed the Office's decision and remanded the case for payment of compensation.

REFUSAL/ABANDONMENT OF SUITABLE EMPLOYMENT

Sandra J. Corson, Docket No. 95-1933, Issued July 2, 1998

In this case, benefits were terminated by the Office on the basis of Section 8106 (c)(2) of the Act.

The claimant was offered a temporary, light-duty nursing job, for five hours per day. The restrictions of the job were in accordance with those recommended by a second opinion specialist and agreed to by the claimant's own attending physician. The claimant was advised by the Office that the job was suitable, and that she had 30 days to accept the job, or provide reasons for refusing it. She was advised that if she failed to accept the position, her reasons for refusing the job would be considered prior to determining whether the reasons for refusal were justified. She was also advised that a claimant who refused an offer of suitable work was not entitled to compensation.

The claimant returned to work, but stated that her left leg was giving out and was causing her to fall. She stopped working that same day. She completed the job offer form by refusing the job, stating that she had a tendency to fall and was at risk for further injury.

The Office advised the claimant that the light-duty job remained suitable and available. The Office did not indicate that it had considered her reasons for refusing the job, and did not advise her whether her reasons for refusal were accepted or rejected. She was given an additional 15 days to report to work or provide additional evidence.

The claimant responded by reiterating that she had refused the job due to left sciatica, and that she was unable to provide additional medical evidence because she had been discharged from treatment by her former physician, and had been unable to locate a new physician.

The Office terminated compensation benefits on the basis of refusing suitable work, and stated that no evidence had been received in response to the job offer. The Office did not advise the claimant that her work stoppage (on the day she returned) was unjustified, did not consider her explanation of why she stopped work, and did not explain why her work stoppage was unjustified. The Board reversed the Office's decision. In doing so, they reiterated the concept that a claimant has a property interest in not having benefits terminated, and a vested interest in not being coerced into accepting a job which may worsen his or her condition. To ensure regularity and impartiality, the Office must not only inform the claimant of the penalty provisions of 5 U.S.C. 8106(c)(2), but must inform him or her that the job is suitable, the consequences of refusing the job, and allow a reasonable period of time for them to accept the job or provide reasons for refusing it. If the claimant provides reasons for refusing a job, the Office must consider those reasons and inform the claimant whether the reasons are accepted or

rejected.

TIMELINESS - OCCUPATIONAL DISEASE CLAIM

George W. Blackmon, Docket No. 95-1872, Issued July 9, 1997

On February 3, 1993, an occupational disease claim was filed for hypertension, coronary artery disease, and stroke. The claimant stated that he first became aware of the conditions on January 17, 1990, and was first aware that the conditions were work-related on February 1, 1993. The claimant had been diagnosed with hypertension as early as 1973. His last exposure to the work factors that were thought to have contributed to the condition was no later than January 31, 1990. He was off from work for diagnostic testing and coronary bypass surgery from January 3 through May 16, 1990, and returned to limited duty. The office denied the claim on the basis that it was not timely filed, stating that he should have been aware that the condition was work-related on January 16, 1990, when he was given the results of diagnostic tests, but did not file a claim for more than three years.

A hearing was requested. The claimant stated that he did not immediately relate his chest pain to his work because he was more concerned with the condition itself than with the cause. The hearing representative affirmed the Office's decision.

The claimant requested reconsideration. He stated that the physician who treated him in 1990 had indicated that his job was not a factor, and submitted reports from 1990 in which the physician indicated that the conditions were not caused or aggravated by employment activity. The claimant stated that he did not realize that his condition was work-related until another physician so informed him on February 1, 1993. Modification of the prior decision was denied. The claimant again requested reconsideration, and submitted a note from his original physician which stated that he had advised the claimant in 1990 that the conditions were not work-related. Modification was again denied.

The Board found that the claim was timely filed. The three-year period for filing a claim did not begin to run until February 1, 1993, when the claimant was first advised that his condition was work-related.

FECA CIRCULAR NO. 99-07 **January 7, 19994**

SUBJECT: **Code changes for the Departments of the Air Force, Army, Defense, Transportation, Treasury, and Veterans Affairs, and the U.S. Postal Service and the Federal Judiciary, Case Management Users' Manual, Appendix 4-7**

The Case Management Users' Manual is being updated and revised to reflect multiple changes, including the addition of several new codes. For the Department of the Air Force, new codes have been added to reflect the establishment of the Air Force Research Laboratory and the Air Force Services Agency. For the Department of the Army, new code 3893 has been added for the National Guard to reflect coverage for the National Guard Youth Challenge Program. For the Department of Defense, several agencies, including the Defense Special Weapons Agency, have combined to form the Defense Threat Reduction Agency, and chargeback code 3004 (formerly assigned to the Defense Special Weapons Agency) is now assigned to this new agency. Certain printing functions have also been assigned to the Defense Logistics Agency, and chargeback code 3034 will henceforth be used for employees of the Defense Automated Printing Service. For the Department of Transportation, a new chargeback code has been added to reflect injuries sustained by cadets at the State Maritime Academies, coverage noted in Chapter 2-0802.18 of the FECA Procedure Manual. For the Department of the Treasury, chargeback code 2150 has been expanded to include not only IRS National Office employees but also employees of IRS Computer Centers in Martinsburg, WV and Detroit, MI and IRS Service Centers in 10 separate cities. For the Department of Veterans Affairs, 4 new codes have been added to reflect injuries reported by employees of newly created offices, and name changes for 2 VA facilities in Indiana have been made. For the U.S. Postal Service, a previously existing code has been changed to reflect injuries reported by employees of the newly created Office of the Inspector General, an organization separate from the Postal Inspection Service. Finally, in the Federal Judiciary, two new chargeback codes has been added to reflect coverage under FECA beginning in October, 1997 for employees of the D.C. Superior Court (code 1370) and the D.C. Court of Appeals (code 1371).

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	3773	Air Force	Air Force Research Laboratory (AFRL)
" "	3774	" "	Air Force Services Agency (AFSVA)
Add	3893	Army	Natl Guard Youth Challenge Program
Add	2535	DOT	State Maritime Academy Cadets
Add	4508	VA	Chief Information Officer
" "	4522	""	Office of Resolution Management
" "	4523	""	Office of Employee Education
" "	4524	""	Health Eligibility Center
Add	1370	Fed Judic	D.C. Superior Court
" "	1371	""	D.C. Court of Appeals

Change 3004 Defense from: Defense Special Weapons Agency
to: Defense Threat Reduction Agency

" " 3034 " " from: Defense Subsistence Supply Center
to: Defense Automated Printing Service

Change 2150 Treasury from: IRS National Office, Washington, D.C.
to: IRS National Office and Service Centers [Includes the Martinsburg, WV and Detroit, MI Computer Centers, and IRS Service Centers (but not Regional or District Offices) located in the following cities: Andover, MA; Austin, TX; Chamblee, GA; Covington, KY; Fresno, CA; Holtsville, NY; Kansas City, MO; Memphis, TN; Ogden, UT; and Philadelphia, PA]; excludes Southeast Region employees stationed in Washington, D.C.

Change 4093 VA from: Fort Wayne VAMC
to: Fort Wayne Campus, Northern Indiana HCS

" " 4097 "" from: Marion VAMC
to: Marion Campus, Northern Indiana HCS

Change 5102 USPS from: Eastern Region, Administration
to: Office of Inspector General

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. 99-08 **January 8, 1999**

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

The interest rate to be assessed for the prompt payment bills is 5.0 percent for the period January 1, 1999 through June 30, 1999.

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 January 31, 1999. The interest rate has been updated in the Debt Management System.

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)

Attachment 1

PROMPT PAYMENT INTEREST RATES

Period	Rate
1/1/99 - 6/30/99	5.0%
7/1/98 - 12/31/98	6.0%
1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

Attachment 2

DMS INTEREST RATES

1/1/99 - 12/31/99	5%
1/1/98 - 12/31/98	5%
1/1/97 - 12/31/97	5%
1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%
1/1/95 - 06/30/95	3%
1/1/94 - 12/31/94	3%
1/1/93 - 12/31/93	4%
1/1/92 - 12/31/92	6%
1/1/91 - 12/31/91	8%
1/1/90 - 12/31/90	9%
1/1/89 - 12/31/89	7%
1/1/88 - 12/31/88	6%
1/1/87 - 12/31/87	7%
1/1/86 - 12/31/86	8%
1/1/85 - 12/31/85	9%
Prior to 1/1/84	not applicable

FECA CIRCULAR NO. 99-09 **March 23, 1999**

SUBJECT: SELECTED ECAB DECISIONS FOR JANUARY - MARCH, 1998

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

The subjects addressed include: rescinding accepted claims for emotional conditions; injury while on temporary duty; abuse of discretion in attorney's fee reduction; death benefits for surviving grandchildren where an eligible widow or widower exists; special weight of a second opinion evaluation upon reexamination; allowing at least 30 days for claimants to submit information required to meet their burden of proof; and authorizing medical treatment recommended after the fact.

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)

ATTORNEY'S FEE APPLICATION - ABUSE OF DISCRETION

Neil R. Stein, Docket No. 96-324, Issued March 4, 1998

Recent changes to the regulations will serve to simplify the process by which OWCP adjudicates application for approval of representative's fees (see FECA Bulletin 99-14). However, when the claimant objects to the amount of the requested attorney's fee, the Office must evaluate the itemized billing according to several criteria.

In the above case, the representative submitted an itemized fee application of $7,705.75 for 23.71 hours of work at an hourly rate of $325.00. The claimant objected to the amount of the fee, stating that the billing time was padded to increase the hours, too much time was shown for standard letters and short telephone calls, the hourly rate was too high, and the initial "free" consultation was included. The claimant did not wish to pay more than $4000.00.

The Office approved an attorney's fee in the amount of $5008.75. The hourly rate of $325.00 was reduced to $175.00 for 1992, and $250.00 for 1993. The Office disallowed the fee for the initial consultation, and reduced the time charged on 36 of the 63 billed services. The Office stated that the time reductions were based on the claimant's statements, and what were judged to be reasonable amounts of time for routine actions.

The Board found that the Office abused its discretion, and remanded the case. The claimant submitted his comments on the fee directly to the Office; the representative did not have the opportunity to address the claimant's objections to the amount of the fee. The representative asked for a copy of the claimant's comments, but was not provided with them.

In addition, the file reflected no documentary information to support the reduction of the hourly rates for 1992 and 1993.

In cases where the claimant objects to the representative's fee, and the claimant's statement has not already been reviewed by the representative, a copy of the claimant's statement should be provided to the representative for comment.

BURDEN OF PROOF - TIME FOR SUBMITTING EVIDENCE

Lenease Norman, Docket No. 95-2973, Issued February 23, 1998

A claim was filed for a traumatic back injury. On July 27, 1995, the claimant was advised of the evidence needed to establish her claim, and was given twenty (20) days to provide that evidence. On August 17, 1995 (21 days later), her claim was denied for failure to establish fact of injury. The Board set aside the decision and remanded the case for further development.

Prior to the recent revision of the regulations, 20 C.F.R. 10.110(b) stated:

> If a claimant initially submits supportive factual and/or medical evidence which is not sufficient to carry the burden of proof, the Office will inform the claimant of the defects in proof and grant at least thirty (30) calendar days for the claimant to submit the evidence required to meet the burden of proof.

The proposed revised regulations issued on December 23, 1997 stated that "up to 30 days" would be allowed for the submission of additional evidence. In section 10.121 of the final rule published on November 25, 1998, however, it states, "the claimant will be allowed at least 30 days to submit the evidence required."

This decision serves as a reminder that, regardless of timeliness standards for issuing decisions, claimants must be given at least the required amount of time (30 days) to submit additional evidence.

DEPENDENT GRANDCHILDREN - DEATH BENEFITS WHEN THERE IS A WIDOW OR WIDOWER

Clyde Stevenson, Docket No. 95-3016, Issued February 4, 1998

The claimant in this case was a widower who was receiving survivor's benefits due to the death of his spouse. He claimed additional survivor's benefits on behalf of his grandson, who was being supported financially by the deceased at the time of her death. The widower gained custody of the grandchild by court order 19 months after his wife's death.

The Office denied the claim for additional survivor benefits initially on August 24, 1994, on the basis that a grandchild was not entitled to compensation if there was a widower receiving compensation. On February 23, 1995, the Office vacated the previous decision and found that there could be concurrent entitlement to survivor's benefits. However, on March 28, 1995, the Office set aside the February 1995 decision. A subsequent hearing decision upheld the denial of benefits on behalf of the grandchild.

The Board found that interpreting 5 U.S.C. 8133 as barring survivor benefits to a grandchild if benefits were being paid to a widow or widower was incorrect. They stated:

> Section 8133 of the Act provides that survivor benefits are payable in accordance with the formula set forth in the statute. It is well established that the Act is a remedial statute and should be broadly and liberally construed in favor of the employee to effectuate its purpose and not in derogation of the employee's rights. A primary rule of statutory construction is to give effect to legislative intent and it is well settled that, in arriving at intent, the statute must be construed in whole, rather than in part.

The Board stated that the intent of the statute was to provide up to a maximum total of 75 percent compensation to any dependent family member, including spouse, child, parent, sibling, grandchild, or grandparent of the deceased. In discussing the intent of the statute, the Board looked at the predecessor of section 8133 in effect until the 1966 amendments. The language of section 8133's predecessor was much clearer with regard to benefits for surviving grandchildren. The Board also quoted from House of Representatives Report that accompanied the 1966 revisions to the Act, which stated that the intent of the bill was to restate the provisions previously in effect, without substantive change. The Board noted that the subparts of Section 8133 were to be read cumulatively, not independently.

The Board reversed the Office's decisions and remanded the case for completion of a form CA-5b, and a determination as to whether the grandchild was wholly or partially dependent on the deceased at the time of death.

MEDICAL TREATMENT - RECOMMENDATION BY PHYSICIAN AFTER THE FACT

Sheila G. Peckenschneider, Docket No. 96-1152, Issued March 25, 1998

This claim was accepted for cervical strain and tendinitis of the left shoulder. The claimant submitted bills for acupuncture treatments she received from December 1991 through March 1994. The Office advised her that acupuncture could be authorized if recommended and supervised by the attending physician, and that periodic reports from the physician to show progress or relief of symptoms would be required. They also advised her that no recommendation for acupuncture or treatment notes were found in her file. The claimant submitted treatment notes from the acupuncturist, who signed as a "licensed acupuncture physician," but there was no indication that this individual was a physician as defined by section 8101(2) of the Act. She also submitted a note from her internist that stated, "The only relief she has ever gotten was from acupuncture. She is to continue acupuncture as medically necessary for pain relief. She has been using acupuncture for the last two and one-half years for pain relief." The claimant also submitted reports from her orthopedic surgeon that recommended that she continue acupuncture treatments. The Office denied payment for the acupuncture treatments.

The Board affirmed the Office's decision. The treatment notes did not constitute medical evidence, since it was not clear that the acupuncturist was a qualified physician. The note from the internist was characterized as "after-the-fact acknowledgment of treatment and its benefits." The Board found that such late recognition of treatment could not substitute for a physician's referral and direction. Neither physician submitted progress reports to show progress or relief of symptoms, nor did they indicate they were supervising the treatments.

PERFORMANCE OF DUTY - COMPENSABLE FACTORS OF EMPLOYMENT - RESCINDING PRIOR ACCEPTANCES

Homer L. Mooney, Docket No. 96-2360, Issued January 13, 1998
Constance I. Galbreath, Docket No. 95-149, Issued March 13, 1998

Both of these decisions involved rescinding prior acceptances for emotional conditions sustained in the performance of duty. The Office's decisions were affirmed in both decisions.

In Mooney, the claim was accepted for major depression and gastritis on March 9, 1994. The acceptance was rescinded on May 28, 1996, on the basis that the claim was accepted in error, and that the condition did not arise in the performance of duty. The Board found that the Office had submitted sufficient new legal argument and rationale to justify the rescission.

The Office found that none of the employment factors cited by the claimant were compensable. The claimant alleged harassment by his supervisor and co-workers. For harassment to be compensable, there must be evidence that harassment actually occurred. The claimant stated that his supervisor placed a deadline on him to complete his route, and followed him on his route. Monitoring an employee's route is an administrative function, and is not compensable absent employer error or abuse. No error or abuse was shown. The claimant stated that his supervisor wrongly allowed another employee to case mail on his route. This again would be an administrative function, and not compensable unless the employer erred or was abusive. Although the claimant received pay for the overtime he lost due to the other employee's work, this action in itself did not establish employer error or abuse. The claimant alleged that his supervisor allowed other employees to laugh at him and tell him he was slow. He did not provide any details or witness statements, and thus the allegations were not established as factual. The claimant also stated that he had an unreasonable workload, that he was forced to complete his route in eight hours, that other employees increased his work by casing his mail, and that substitute carriers increased his work by leaving mail for him to deliver the next day. Although these factors could be compensable, the claimant had not established them as factual.

In Galbreath, the claimant alleged disability due to being "verbally attacked, abused and humiliated" by the Human Resources Field Director on one single occasion. The employer controverted the claim, and submitted a statement from a witness to the events from the claimant's acting supervisor. The claim was accepted in September 1990, then rescinded in March 1994. In rescinding the prior acceptance, the Office explained that the claim was originally accepted based on the claimant's allegation of harassment, but no finding of harassment had ever been made. The Field Director met with the claimant to discuss her job performance, and to issue a letter of warning. This discussion would be considered an administrative function, and would not be compensable unless there was error or abuse by the employer. The witness to the discussion stated that the discussion was routine and professional, and that there was no strong language used.

The Board affirmed both the March 1994 rescission and a later reconsideration decision. In support of the request for reconsideration, the claimant argued that the employer had shown error or abuse, because through an EEOC settlement, the letter of warning was removed, and a monetary settlement made. However, the EEOC decision made no finding of discrimination, and the terms of the settlement were such that neither party admitted to any wrongdoing.

These two decisions are further illustrations of the importance of clearly delineating between compensable and non-compensable employment factors.

PERFORMANCE OF DUTY - INJURY WHILE ON TEMPORARY DUTY

Jack E. Talbert, Docket No. 94-1810, Issued February 10, 1998

The claimant in this case was on temporary duty while performing an audit in Dallas, Texas. He tore the Achilles tendon of his right leg while playing basketball with a co-worker on the hotel grounds. The audit was being conducted at another location approximately one-half mile from the hotel.

The district office denied the claim on the basis that the injury did not occur in the performance of duty. The Board affirmed the decision.

Employees who travel while on temporary duty assignments are generally considered to be in the performance of duty during the trip, but there are limitations to the coverage. Injuries that arise out the necessity of sleeping in hotels or eating in restaurants are usually compensable. Personal errands that depart from the necessary routine are not compensable. In this case, the claimant was engaged in a personal, recreational activity when he was injured. His activity was not directed by his employer, and was not a necessary part of his temporary duty status. Even though he was on the hotel grounds at the time of injury, he was not in the performance of duty.

SECOND OPINION EVALUATION - SPECIAL WEIGHT UPON REEXAMINATION

Cerlestine Evans, Docket No. 96-1684, Issued March 13, 1998

The claimant in this case sustained a left knee injury. Knee surgery was authorized by the Office, but the underlying condition of osteoarthritis was not accepted.

In April of 1994, the claimant was examined by Dr. Nelson, a Board-certified orthopedic surgeon, for a second opinion. He stated that her total disability ceased prior to her return to work in March 1991, but did not give reasons for his opinion. He did not address whether the claimant's underlying condition had been aggravated by the work injury.

Subsequent reports from the claimant's attending physicians supported that her condition continued to be work-related, although the reports were not well-rationalized.

The claimant was referred to Dr. Nelson for another second opinion in May 1995. Dr. Nelson stated that the additional surgery being proposed by the claimant's physicians would not be beneficial for her knee pain, and that her preexisting disability did not increase with the work injury. He did not support his opinions with medical rationale.

The Office terminated the claimant's benefits on the basis of Dr. Nelson's reports. In assessing the medical evidence, the office attributed special weight to Dr. Nelson's second report because "he had previously performed a second opinion examination in 1994, such that he was able to assess changes in appellant between 1994 and 1995 and had the benefit of a complete and accurate knowledge of appellant's medical and factual history."

The claimant subsequently requested reconsideration and submitted a report from her physician, disagreeing with Dr. Nelson's statements. Modification was denied, and the office stated that Dr. Nelson's opinion was thorough and well-rationalized.

The Board reversed the Office's decision, finding that there was an unresolved conflict of medical opinion that required referral to an impartial medical specialist. Neither Dr. Nelson's nor the attending physicians' opinions were well-rationalized. The Board also made special note that the second opinion physician's reports were not entitled to special weight by virtue of his having seen the claimant previously and being able to compare findings over time.

FECA CIRCULAR NO. 99-10 **March 22, 1999**

SUBJECT: Selected ECAB Decisions for April-June, 1998

The attached group of summaries of selected ECAB decisions is provided to point out novel issues recently addressed by the Board.

Included in this FECA Circular are summaries on the performance of duty and on use of leave for hearings.

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)

PERFORMANCE OF DUTY--HARASSMENT

Christophe Jolicouer, Docket No. 1996-0597, Issued June 11, 1998

In this case, the Board discusses specifically whether shouting and/or cursing by a supervisor at a subordinate will be considered harassment.

The claimant was a 40-year-old examiner assistant. His acting supervisor ordered him to look for a missing roll of forms. Not finding the forms, he returned to his usual duties. Upon noticing this, the acting supervisor scolded him for not continuing to look for the "damn" forms. A witness confirmed this encounter.

The Board found that this was an isolated comment from the acting supervisor, and that, as the claimant had not shown how this incident rose to the level of verbal abuse, this would not fall within the performance of duty.

PERFORMANCE OF DUTY--TRAVEL

Kathleen M. Fava, conservator, Docket No. 1995-0268, May 18, 1998

In this case, a federal employee suffered severe head injuries while in a travel status which eventually led to his death. The claim was initially accepted but later rescinded on the basis of new factual evidence.

The employee, a 38-year-old aircraft electrician, was on temporary duty status when injured. He and two co-workers also on temporary duty went sightseeing and to dinner. They were to return to temporary duty the following day. During the evening, they played pool and drank beer at a sports bar, followed by dinner and then a return to the sports bar for additional games of pool and more beer.

They left the bar at 11:00 p.m. to return to the campus where they were staying. Their van was parked at the end of a grassy area with a retaining wall. The employee turned to speak as he approached the end of the retaining wall and fell to the pavement (approximately three feet), striking his head. He was unresponsive and bleeding from the head and nose.

His companions took him back to the campus in the van, and medical attention was summoned. The employee was comatose and in critical condition. He was also found, the following morning, to have a blood alcohol level of .166.

The Office initially accepted the claim, but later rescinded the acceptance, finding that the drinking and playing pool were not reasonably incidental to the TDY mission. This was based upon new information, notably statements from the parties present at the time of injury.

The conservator of the estate later requested reconsideration, but review was denied.

The Board found that the recission of acceptance was correct when issued, as the drinking beer and playing pool were, indeed, not incidental to the TDY. However, the Board also found that the new evidence submitted with the reconsideration request was sufficient to require further development.

Specifically, upon return to the campus, the employee may have suffered additional injuries, and the Board found that these injuries may have the potential to be within the performance of duty. The later incidents, which involved his removal from the van by his apparently intoxicated companions, occurred at the quarters to which he was assigned and while he could not be said to be engaged in personal or recreational activities.

The Board found that the deviation created by his travel to the sports bar ceased when he was returned to his quarters. The case was remanded for medical development of the extent of his

injuries upon return.

LEAVE REPURCHASE

Raymond H. Chandler, Docket No. 1996-1225, April 13, 1998

In this case, the claimant filed a claim for compensation attempting to repurchase leave used to attend a hearing with an Office Hearing Representative.

The Board found that, as neither the Act nor its implementing regulations contain any provision authorizing such payment, the Office and the Board may not create such a provision. OWCP's denial of the claim for leave repurchase was affirmed.

FECA CIRCULAR NO. 99-11 **April 22, 1999**

SUBJECT: Selected ECAB Decisions for July-September, 1998

The attached group of summaries of selected ECAB decisions is provided to point out novel issues recently addressed by the Board.

Included in this FECA Circular are summaries on payment for authorized supplies, civil employee, idiopathic falls, and overpayments and the ability to make repayment.

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)

MEDICAL EXPENSES AND TREATMENT--SERVICES, APPLIANCES, AND SUPPLIES

James R. Bell, Docket No. 1995-2786, Issued August 20, 1998

In this case, the claimant requested reimbursement for operating expenses for electricity and water for a Jacuzzi whirlpool spa. OWCP had previously authorized the purchase of the spa as related to treatment for the accepted condition.

The request for reimbursement was denied because the specific expenses incurred were not provided for under section 8103(a) of the Act.

The Board found that the approval of services, appliances, and supplies is within the discretion of OWCP, and that this discretion has been construed broadly to be defined as those items considered by OWCP likely to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of monthly compensation. The Board also found that while a contrary conclusion might have been reached, this decision was within the limits of reasonableness and not an abuse of discretion.

CIVIL EMPLOYEE

Jane Doe, Docket No. 1996-2477, August 24, 1998

In this case, the appellant was a student, completing a phlebotomy laboratory rotation at a Veterans Administration Medical Center (VAMC) when she was stuck by a needle. The VAMC filed a claim for her injury, and the claim was accepted, as OWCP found her to be an employee of the VAMC who was injured in the performance of duty.

The student then appealed that decision, contending that she was not a VAMC employee as she had not signed a letter of appointment activating her student status.

The Board affirmed the Office's decision, finding that Ms. Doe was an employee for purposes of the Act because there was a statute allowing the VAMC to accept her unpaid services and because the services provided by her were substantially similar to those provided by paid employees.

IDIOPATHIC FALLS

Joseph C. Gunter, Docket No. 1997-0246, September 22, 1998

In this case, the claimant filed a claim for compensation after undergoing a syncopal episode while driving a postal vehicle and colliding with another vehicle. The Office denied the claim, finding that the syncope could not be found to have occurred within the performance of duty. A laceration of the left brow was accepted, however, as related to the resultant automobile accident.

The Board reversed the Office's decision, noting that no physician provided any specific underlying cause for the syncopal episode. Rather, the episode remains unexplained, so all injuries resulting from it, as well as the expense for the resultant hospitalization and diagnostic workup are compensable.

Claims Examiners are reminded that evidence that a fall or syncopal episode may have some explanation in the claimant's medical history, without a definitive medical opinion confirming this, is not sufficient to find that all injuries resulting therefrom are not compensable. Rather, any fall/blackout not specifically identified by a physician as related to an underlying medical problem should not be considered idiopathic, but should instead be viewed as unexplained and the resultant claim adjudicated accordingly.

OVERPAYMENTS

Adolphus Bennett, Docket No. 1996-2009, Issued July 8, 1998

In this case, the claimant was found to have excess income such that recovery of an overpayment would be necessary. The claimant was found to have been without fault in the creation of an overpayment due to five years of health insurance non-deduction.

In computing the claimant's ability to repay, the Office included the claimant's son's earnings in computing his ability to repay the debt. No finding was made, however, as to whether the son's income was "reasonably available" to the claimant.

The Board, therefore, remanded the case for further development of this issue. Senior Claims Examiners are reminded that findings of fact must be made in such a scenario, when income other than that of the injured employee and his or her spouse is included in the computation.

FECA CIRCULAR NO. 99-12 **April 26, 1999**

SUBJECT: Revised CA-7

FECA Bulletin 99-18, dated December 24, 1998, notified offices of the revised Form CA-7, "Claim for Compensation," and provided procedures for its use.

The first printing of the revised CA-7 showed a revision date of July 1997. The correct revision date is November 1998. Printings subsequent to the first will reflect the correct 1998 revision date. The July 1997 printing of the form is identical to the November 1998 version, except for the revision date, and may be used.

In addition, the Government Printing Office stock number provided in FECA Bulletin 98-18 is incorrect. The correct stock number for the revised CA-7 is 029-016-00198-1.

SHEILA M. WILLIAMS
Acting Director for
Federal Employees' Compensation

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

FECA CIRCULAR NO. 99-13 **July 1, 1999**

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

The interest rate to be assessed for the prompt payment bills is 6.5 percent for the period July 1, 1999 through December 31, 1999.

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, 1999.

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

SHEILA M. WILLIAMS
Acting Director for
Federal Employees' Compensation

Attachments

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

Attachments to FC 99-13

PROMPT PAYMENT INTEREST RATES

Period	Rate
7/1/99 - 12/31/99	6.5%
1/1/99 - 6/30/99	5.0%
7/1/98 - 12/31/98	6.0%
1/1/98 - 6/30/98	6 1/4%
7/1/97 - 12/31/97	6 3/4%
1/1/97 - 6/30/97	6 3/8%
7/1/96 - 12/31/96	7.0%
1/1/96 - 6/30/96	5 7/8%
7/1/95 - 12/31/95	6 3/8%
1/1/95 - 6/30/95	8 1/8%
7/1/94 - 12/31/94	7.0%
1/1/94 - 6/30/94	5 1/2%
7/1/93 - 12/31/93	5 5/8%
1/1/93 - 6/30/93	6 1/2%
7/1/92 - 12/31/92	7.0%
1/1/92 - 6/30/92	6 7/8%
7/1/91 - 12/31/91	8 1/2%
1/1/91 - 6/30/91	8 3/8%
7/1/90 - 12/31/90	9.0%
1/1/90 - 6/30/90	8 1/2%
7/1/89 - 12/31/89	9 1/8%
1/1/89 - 6/30/89	9 3/4%
7/1/88 - 12/31/88	9 1/4%
1/1/88 - 6/30/88	9 3/8%
7/1/87 - 12/31/87	8 7/8%
1/1/87 - 6/30/87	7 5/8%
7/1/86 - 12/31/86	8 1/2%
1/1/86 - 6/30/86	9 3/4%
7/1/85 - 12/31/85	10 3/8%
1/1/85 - 6/30/85	12 1/8%

DMS INTEREST RATES

Period	Rate
1/1/99 - 12/31/99	5%
1/1/98 - 12/31/98	5%
1/1/97 - 12/31/97	5%
1/1/96 - 12/31/96	5%
7/1/95 - 12/31/95	5%

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

FECA CIRCULAR NO. 99-14 August 30, 1999

SUBJECT: Loss of Wage Earning Capacity--Actual Earnings from Temporary Positions

Recently, some confusion has arisen about the proper method of determining the wage-earning capacity of temporary employees who are injured and return to work in new temporary positions prior to the expiration of their original appointments.

Specifically, the issue is: must a temporary position last at least as long as the time remaining on the original appointment before OWCP can determine that the actual earnings of that position fairly and reasonably represent the wage-earning capacity of a worker who was a temporary employee when injured?

The length of any temporary position to which the employee returns must be at least 90 days before the actual earnings from such a temporary position can be used to calculate an employee's loss of wage-earning capacity. However, the work need not continue for the length of the original appointment.

For example, an employee who is injured two months into a six month appointment need not return to work in a job lasting six months. Rather, an appointment lasting three months will be sufficient to determine that the job fairly and reasonably represents his or her wage-earning capacity. The rating for loss of wage-earning capacity may be done after 60 days of employment, as with any other employee.

This issue should not be confused with the suitability of a job offer made by an agency to a temporary employee. The employee is obligated under 5 U.S.C. 8106(c) to accept suitable employment, or lose entitlement to compensation. In making a finding of suitability of a job

offer to a temporary employee, a position that will continue for a minimum of 90 days will be considered suitable, provided that all other required criteria are met.

The Federal (FECA) Procedure Manual in Chapter 2-814.4b(3), which pertains to offers of employment, states that:

> A temporary job will be considered unsuitable unless the claimant was a temporary employee when injured and the temporary job reasonably represents the claimant's WEC. Even if these conditions are met, a job which will terminate in less than 90 days will be considered unsuitable.

Therefore, temporary employment offered to a temporary employee who has not returned to work must not be less than 90 days in duration. Otherwise, the job cannot be considered suitable.

These are two separate issues and different criteria apply.

SHEILA M. WILLIAMS
Acting Director for
Federal Employees Compensation

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

FECA CIRCULAR NO. 99-15 **August 15, 1999**

SUBJECT: Selected ECAB Decisions for October - December 1998

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 a willful misconduct decision, a decision on a "learner's capacity" determination, a decision on non-cooperation with rehabilitation, a decision regarding performance of duty, and several decisions addressing loss of wage-earning capacity determinations. 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.

NANCY L. RICKER
Acting Director for
Federal Employees' Compensation

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

WILLFUL MISCONDUCT

Shirley C. Graham, Docket No. 96-2053, issued October 13, 1998

The claimant injured her back, right leg and right shoulder when she fell over a drawer that she alleged was placed in her way by another employee. The Board found that the Office improperly determined that due to statutory willful misconduct the employee was not covered under the Act.

The claimant was a 59-year-old secretary whose work area was being remodeled along with the work areas of co-workers in her office. She had been directed to remove writing which she had done directly on the office furniture, at the same time that contractors were building cubicles for the new work space. When the contractors complained about the claimant removing and returning office furniture to the work space while they tried to work, the claimant's acting supervisor instructed all of the secretarial staff to stay out of their way while they built the cubicles.

Some hours later, the supervisor observed the claimant continuing to move items to and from her office, so he advised her directly to stop. The claimant was thereafter observed by her acting supervisor and another manager to make a defiant statement and to continue dragging the items of furniture into her office. The witnesses stated that shortly afterwards a thump was heard as a result of her falling over one of the items she had dragged into her area against the instructions of her superior.

The Office denied the claim finding that the claimant's actions were deliberate and intentional, and as such constituted willful misconduct. The Board, on reversing this decision, made the distinction between disobeying a direct order of a superior, and intentionally violating a known safety regulation. The Board pointed out that even though the claimant clearly did disobey a direct order from her superior, there was no evidence to support that the order was phrased as a direction for her to avoid bodily harm such as in a safety rule. The Board stressed that the claimant did not intentionally violate a known regulation designed to save her from serious bodily harm. As background discussion, it referred to § 8102 (a)(1) of the FECA which states that coverage under the Act is afforded when an injury or death is in the performance of duty unless it is "caused by the willful misconduct of the employee…" The Board goes on to explain that the "willful misconduct" defense (which is an affirmative defense 1) has been limited to the deliberate violation of known regulations designed to preserve the employee from serious bodily harm (from *Larson's Workmen's Compensation Law*). Moreover, the Office must prove that the employee understood the "seriousness of the consequences attending violation of the safety rule since otherwise his conduct can only be described as heedless rather than deliberate and intended to harm himself.

1 Affirmative defense means that the Office has to prove that it did occur, rather than the cliamnat having to

provive or support that it did not occur in this manner.

LWEC/NON-PARTICIPATION IN REHABILITATION

CORLISIA L. SIMS, Docket 97-842, issued December 23, 1998

The employee was a Postal Worker who had suffered two injuries at work on February 12, 1992, and a cervical and right shoulder strain on March 18, 1993. Due to her permanent residuals from the employment injuries the claimant was referred to the rehabilitation program. After being placed in an interrupt status by rehab due to her pregnancy, the claimant was again activated and signed a rehab training plan to participate in an associate degree program in social work.

Sixteen months after signing the training rehabilitation plan, and after several failures to comply with the terms of the agreement and numerous opportunities to show cooperation with the rehab program, the Office issued a proposal to reduce the claimant's benefits. One month after receiving the claimant's response to the proposed reduction, the Office finalized the proposed reduction finding that the claimant had failed to show good cause for her failure to continue with her training program and to undergo vocational rehab as directed in accordance with the provisions of § 8113(b) of the FECA.

The Board affirmed the decision, ruling that the Office properly reduced the claimant's benefits prospectively. It noted that the claimant's wage-earning capacity would have been that of a social work aide had she undergone vocational rehabilitation according to her agreement. It pointed out that the Office may direct a partially disabled claimant to undergo rehab under § 8104 of the Act. The Appeals Board added that, should the claimant fail to cooperate without good cause, the Office may find under § 8113(b) that the wage-earning capacity would have been that of the targeted position had the agreed-upon training program been completed, and may reduce compensation benefits accordingly. The Board observed upon review of the case that the claimant had been counseled on several occasions regarding her noncompliance with the rehab plan, that she refused to participate in telephone conferences with the Office and her rehab counselor, and that she was given another chance to cooperate but refused to participate in required math courses. The Board pointed out that evidence from all sources including her college instructors, college transcripts, her rehab counselor and the rehab specialist amply supported the claimant's non-cooperation, non-responsiveness, and non-participation with the goals of her vocational rehabilitation program.

LOSS OF WAGE-EARNING CAPACITY (LWEC)

Robert Carlisle, Docket No. 97-1299, issued December 3,1998;
Paul Day, Docket No. 96-1888, issued October 8, 1998;
Shirley Murphy, Docket No. 95-2417, issued October 7, 1998;
Carla J. Hammond, Docket No. 97-78, issued December 7, 1998

In three of the above four compensation claims, the LWEC determination was reversed, and in the last the decision was set aside. In all four claims the Office was correct in its finding that the claimant was no longer totally disabled but could not return to the date-of-injury job. In Robert W. Carlisle the Board observed:

> Once the medical evidence suggests that a claimant is no longer totally disabled but rather is partially disabled, the issue of wage-earning capacity arises… If an employee does not have any actual earnings, his or her wage-earning capacity is determined with due regard to the nature of the injury, the degree of physical impairment, the employee's usual employment, age, qualifications for other employment, the availability of suitable employment and other circumstances…

In all four of the above cases, the Board ruled that the Office failed to base its decision on a solid finding of suitability of the employment position selected for the LWEC rating. In Carlisle, the Office relied on the Rehabilitation Specialist's selection of the position of Shipmate without confirming the claimant's ability to perform the duties of the position. The Board pointed out that "the Office must consider not only physical limitations, but also education, age and prior experience." In this case the Board noted that the claimant did not have the vocational skills to competitively perform the selected position in the open labor market. In Paul Day the Office selected a position for rating based on a Rehabilitation Specialist's recommendation that had been made 4 years in the past, and on a second-opinion specialist's report that was internally contradictory. On reversing this decision, the Board found that the Office would have to refer the claimant to an appropriate physician to clarify his work restrictions, to determine whether the position of auto service station attendant would be available to him in view of his restrictions, and to verify that this position would still be available in the claimant's commuting area through the present time.

In Shirley Murphy, again, the Board found that the Office's error was in the selection of a position that was suitable employment for the claimant in view of her disability. The claimant had both physical and psychiatric diagnoses accepted by the Office as caused or aggravated by her employment injury. The Office reduced her benefits based on the selected position of full-time cashier. In noting the deficiencies in this decision, the Board pointed out that the Rehabilitation Specialist's recommendation was more than a year old, that the medical opinion

which supported the job as suitable was 2½ years old, and that the report was not based on a complete and accurate history resulting in its being of diminished probative value. Furthermore, the Board noted that the duties of the position selected (cashier) were in direct contradiction to the claimant's psychiatric restrictions of no time pressures and no public contact.

In the Carla J. Hammond decision, the Office made a finding that the claimant's earnings in a light duty position with her original employer for 4 hours per day represented her wage-earning capacity. In setting this decision aside the Board referred to the Office's own procedures which provide as follows:

> …Reemployment may not be considered suitable when: (1) the job is part-time (unless the claimant was a part-time worker at the time of injury) or sporadic; (2) the job is seasonal…, or (3) the job is temporary where the claimant's previous job was permanent.

The Board also noted that the Office failed to make *any* specific findings with regard to whether the actual earnings fairly and reasonably represented the claimant's wage-earning capacity. The case was therefore remanded for proper findings on the issues presented and an appropriate decision.

LOSS OF WAGE-EARNING CAPACITY (LWEC) AFFIRMED

Elijah Small, Docket No. 96-2277, issued October 6, 1998; Gary Michael Connatser, Docket No. 96-2184, issued October 16, 1998

In Elijah Small, the Office relied on a vocational rehabilitation counselor's recommendation that the job of Security Guard was within the claimant's physical restrictions, that it was reasonably available within the commuting area and that the claimant was vocationally prepared for performing the duties. Once the Office issued its LWEC determination, the claimant requested a reconsideration, and in support of such request, submitted a medical report from his physician which was substantially the same as his previous report. The Board noted that the physician had previously approved the position of Optometry Clerk and felt that the duties of Security Guard exceeded those of the former position. However, the Board pointed out that the physician had not actually reviewed the duties of the Security Guard position, and that the physician, as before, indicated that the claimant could work within the restrictions provided in the functional capacity evaluation. As such, the Board noted that the new medical report was no more than a reiteration of the previous report and was not sufficient to require the Office to reconsider the merits of the claim.

In Connatser, the Office reduced benefits based on the claimant's ability to perform the duties of a Mechanical Engineering Technician. Vocational Rehabilitation services had been provided to the claimant for a period of five years at the time the determination was made. Additionally, the claimant received training and attended a community college with completion of an Associate of Science (A.S.) degree. He attended two additional years with a concentration in Biomedical Engineering, and he received job placement services for more than 3 months at the end of the vocational rehab process. However, even though the claimant received high scores on intelligence quotient (IQ) tests, between 110 and 138, he was academically unable to complete a Bachelor's Degree program at the university he attended for two years. The claimant's rehab counselor along with the Vocational Rehabilitation Specialist found the claimant vocationally qualified to perform the job of Mechanical Engineering Technician based on his 11 years as a metal fabricator/sheetmetal worker, his A.S. degree, and his two years of coursework at the university. Despite the claimant's assertions that he was unable to complete his Bachelor's Degree because of his being ill, due to not being given a tutor, and to a psychiatric condition alleged resulting from his accepted employment injury, and despite his obtaining a letter from the director of placement at the community college, the Board found that the Office's decision to reduce benefits was well supported by the evidence of record. The Board noted that the claimant had been given proper notice of the intention of the Office to reduce benefits and the opportunity to present evidence and argument in opposition to the reduction. The case record reflected that the claimant's arguments were given full consideration and that the Office sought clarification by writing to the community college placement director and speaking with him to evaluate his earlier statements. The Board concluded that in view of all the facts in this case the Office's

finding that the position of mechanical engineering technician fairly and reasonably represented the claimant's wage-earning capacity should be affirmed.

PAY RATE FOR COMPENSATION PURPOSES: LEARNER'S CAPACITY

David J. McDonald, Docket No. 96-1144, issued December 10, 98

The Board ruled that the claimant was not employed in a "learner's capacity" when injured such as to entitle him to additional compensation under 5 U.S.C. § 8113(a).

The claimant was a GS-9, step 3 Customs Inspector when he filed his compensation claim. The Office accepted temporary aggravation of his pre-existing heart condition, a subsequent myocardial infarction, angina episode, and further aggravation of the claimant's heart condition. The claimant later alleged that he was entitled to a higher rate of compensation because he had been employed in a learner's capacity at the time of his injuries within the meaning of 5 U.S.C. § 8113(a) which provides as follows:

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

The Office denied the claim for an increased pay rate on the grounds that the claimant was not employed in a learner's capacity at the time of his injuries so as to be entitled to additional compensation under § 8113(a) of the Act. On affirming the Office decision, the Board noted that the case record contained personnel documents indicating that the "full performance level" of the custom inspector's position was GS-9, and that the employing agency had described the status of the position as follows:

> The full performance or journeyman level of (claimant's) position is GS-9 with no further
> promotion potential in the present position

.
The Board's discussion also referred to other decisions in which the appropriate circumstances for finding an employee to have been in a learner's capacity within the meaning of the Act had been delineated, e.g., *Carter C. Swinson,* 10 ECAB 281; and *James L. Parkes,* 13 ECAB 515. In *Swinson* the job title of the position being considered was that of "helper-machinist trainee." The employing agency explained that the only formal training program for machinists was the apprenticeship program and that the claimant was not enrolled. The employer further stated that the job classification of 'helper-machinist' was not an "in-training" position, and that while some

helpers were promoted to machinist based on demonstrated ability, the majority were not. The Board added that the designation of helper or of trainee is not sufficient to render the employee a "learner" within the meaning of the Act. It added that the title given to a job is not, of itself, determinative of this issue, nor is the fact that an employee was engaged in an unskilled job which may or may not lead to a semiskilled or skilled craft, bring him or her within the meaning of "learner" such as to afford coverage under the Act. Similarly, in *Parkes*, the claimant was not in a formal training program with a specified period for completion after which he would have moved to a higher grade. *Parkes* could have remained in the same position indefinitely, and if he *was* promoted, it would have been the result of his proven ability, experience, or other qualifications.

The Board pointed out that in the present case, as in *Parkes*, the claimant was not a participant in a formal training program in which, after a specified period for completion, he would have been automatically promoted to a higher grade. The employing agency stated that advancement from the customs inspector's position required either promotion through competition with other qualified individuals, or through "accretion of duties" which occurs when an employee performs duties above his or her grade level. The Appeals Board affirmed the decision that the claimant was not entitled to any increase in compensation payable as he was not found to have been in a "learner's capacity" within the meaning of the Act; and it held that the Office had not abused its discretion by refusing to reopen the case for consideration of the merits of the claim.

FECA CIRCULAR NO. 99-16 **September 21, 1999**

SUBJECT: Revised Form CA-1

Form CA-1 was revised to reflect the revision to the Federal Regulations that requires that work stoppage begin within 45 days of the date of injury (rather than the previous 90 days) in order for an employee to be eligible for Continuation of Pay. Some additional revisions are included for the sake of clarity.

Existing stock of CA-1s should be replaced with the revision because the regulatory change makes all existing versions inaccurate. A copy of the form, revised in April 1999, is attached. Supplies are now available in the warehouse and orders should be placed through regular channels. Any agency who produces their own CA-1 forms should make the revision immediately. You will know that the CA-1 available on the internet has been revised when it reflects a revision date of April 1999. This may be accessed at

http://www.dol.gov./dol/esa/public/regs/compliance/owcp/fecacont.htm

NANCY L. RICKER
Acting 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. 99-17 **September 21, 1999**

SUBJECT: SELECTED ECAB DECISIONS FOR JANUARY – MARCH, 1999

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

The subjects addressed include: dual benefits; overpayments; performance of duty; recurrence vs. new injury; refusal of suitable employment; rescinding acceptance of a claim; schedule award; terminating medical benefits; timeliness of request for reconsideration or hearing; wage-earning capacity-actual earnings; wage-earning capacity-constructed position; weighing medical evidence.

Nancy L. Ricker
Acting Director for
Federal Employees' Compensation

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

DUAL BENEFITS - SEVERANCE PAY

William Taylor, Docket No. 97-1540, Issued February 1, 1999

In this case, the issue under consideration by the Board is whether the claimant is entitled to compensation for total temporary disability for the same period in which he received separation incentive pay. The claimant received continuation of pay from an accepted traumatic injury from January 14, 1994 through February 3, 1994. He then accepted voluntary separation incentive pay for a period of 30.82 weeks. The claimant filed an occupational disease claim, which was accepted, and a schedule award was paid on this claim for 144 weeks running from March 17, 1995 through December 18, 1997. The claimant requested compensation for total temporary disability for the period February 4, 1994 through March 16, 1995. By decision dated March 12, 1997, the Office found, among other things, that the claimant voluntarily retired from his job on February 3, 1994, that the personnel action showed that his reason for separation was to obtain retirement benefits, that he received separation incentive pay from his employer for 30.82 weeks and that the appellant was not entitled to any disability compensation for the period February 3, 1994 to September 6, 1994 because he received incentive pay for that period. The claimant argued that he was entitled to both the separation incentive pay and compensation for total temporary disability.

The Board noted that the claimant accepted a lump-sum payment of separation incentive pay upon voluntarily retiring form his employing agency. This separation incentive pay was remuneration from the United States in consideration of his voluntary retirement. This separation incentive pay, therefore, falls under both the category of "pay" and the category of "remuneration of *any* type" as specified in 5 U.S.C.§8116. Consequently, the Board held that the claimant was not entitled to compensation for wage loss during the period in which he received the separation incentive pay.

OVERPAYMENT-ASSISTED RE-EMPLOYMENT

Michael K. Montgomery, Docket No. 97-2882, Issued March 10, 1999

There were two issues before the Board in this claim. However, the issue of interest pertains to the decision of whether the Office properly found an overpayment of compensation for the period January 25, 1995 to July 20, 1996. The injured worker was employed under the assisted re-employment program from January 27, 1995 to May 8, 1996. The injured worker's compensation was not reduced based on his actual wages during this period. The Office found that an overpayment existed because he was earning wages during the period in question and, therefore, was not entitled to total temporary disability. The injured worker argued that the time period during which he worked under the assisted re-employment program should not be considered in a calculation of his overpayment because it should be considered an authorized rehabilitation training program.

The Board held that, while the Federal Procedure Manual indicates an injured worker may receive benefits for temporary total disability while participating in an authorized rehabilitation program, there is no indication that the injured worker would be entitled to these benefits once he is employed. Thus, the Office properly determined that the injured worker was not entitled to total temporary disability during the period he was participating in the assisted re-employment program.

PERFORMANCE OF DUTY - OFF PREMISES INJURY

<u>Kurt A. Hickman, Docket No. 97-1042, Issued January 5, 1999</u>

This claimant fell and broke his hip and injured his wrist on the way to work. On the date of injury, conditions were icy. The claimant telephoned his supervisor at work and told him that due to the ice, he could not get his car out of the driveway, and could not come in to work. The supervisor offered to give him a ride, and they arranged for the claimant to be picked up on the street corner. As the claimant was approaching the supervisor's vehicle, he slipped and fell approximately 20 feet from the vehicle.

The employer controverted the claim on the basis that the injury did not occur in the performance of duty. The Office denied the claim on the basis that the injury did not occur in the performance of duty. A hearing was requested, and the hearing representative affirmed the Office's decision.

The Board also affirmed the Office's decision. Injuries that occur off the premises while an employee is commuting to work are generally not compensable. The recognized exceptions to this general rule are: (1) where the employer requires the employee to travel on the highway; (2) where the employer contracts to and does furnish transportation to and from work; (3) where the employee is subject to emergency calls (as with firemen); and (4) where the employee uses the highway to do something incidental to his employment with the knowledge and approval of the employer.

None of these exceptions applied in this case. On the date of injury, the supervisor agreed to provide transportation as a courtesy. When transportation is directly provided by the employer, the vehicle in which transportation is provided is considered to be an extension of the premises, and therefore, an injury that takes place while riding in employer-provided transport occurs on the premises and is compensable. In this case, however, the claimant had not yet reached the "premises" (the supervisor's truck) when he was injured.

The proximity rule was also not applicable since he was on a public street when injured, and not near his workplace.

RECURRENCE IN OCCUPATIONAL DISEASE CLAIM - NEW INJURY

Tyrone E. Murray, Docket No. 96-613, Issued January 29, 1999

The Office accepted that the claimant, a modified distribution clerk, sustained de Quervain's tendinitis of the right wrist, right lateral epicondylitis, and subacromial bursitis of the right shoulder due to his job duties. He received compensation for intermittent periods of total disability until July 2, 1994, when he returned to work filing mail.

The claimant filed a claim for recurrence of disability as of April 7, 1995. He stated that after he returned to work, he developed problems with his left hand, wrist, and shoulder from filing mail, and when he started to use his right hand, wrist, elbow and shoulder, they began to fail. He did not stop working until July 5, when he stopped working for reasons other than his right hand, wrist, elbow, and shoulder problems.

The Office denied the claim for recurrence, and found that both the claimant and his physician described a new injury, rather than a recurrence. The claimant was advised to file a new Form CA-2. A subsequent reconsideration request was denied.

The Board affirmed the Office's decision, finding:

> If the appellant's claim for a recurrence of disability is actually, as indicated by his … letter, a claim that his employment duties since his return to work on July 5, 1994 caused a left arm condition and a worsening of his right arm condition, the Office was correct in informing him that this was a new injury and not a recurrence of disability related to his prior accepted condition. The Office should have adjudicated this claim for a new injury, as there is no requirement that a claim be filed on an Office form, but, as it did not do so, the Board cannot review this aspect of appellant's case on appeal.

REFUSAL TO ACCEPT SUITABLE EMPLOYMENT - CONDITIONS SUBSEQUENT TO INJURY

Robert Steele, Docket No. 97-441, Issued January 4, 1999

The claimant in this decision was a distribution clerk who sustained a work-related herniated lumbar disc. His treating physician provided a work capacity evaluation which indicated he could work eight hours per day with restrictions. On March 5, 1996 his employer offered him a limited-duty job. On March 6, 1996, the Office informed him that the job was suitable, that refusal of suitable work would be a basis for termination of compensation, and that he had 30 days to accept the position or give reasons for refusing it. On March 7, 1996, the claimant rejected the job offer, stating that he did not get along with the postmaster, and that he was physically unable to work. On April 16, 1996, the Office informed the claimant that his reasons for rejecting the job offer were unacceptable, and he was given an additional 15 days to accept the job offer. On April 23, 1996, the claimant's wife advised the Office that the claimant could not work because he was hospitalized. On May 26, 1996, the Office suspended compensation due to his refusal of suitable work.

The claimant requested reconsideration on August 6, 1996, and submitted reports from a psychiatrist which indicated that he had been hospitalized for bipolar disorder, and that medication and further inpatient care was recommended. The Office issued a decision terminating compensation on August 20, 1996.

In reversing the Office's decision, the Board cited Chapter 2.814.4(b)(4) of the Federal (FECA) Procedure Manual, which provides that if medical reports document a medical condition which arose after a work injury, and which disables the claimant for the offered job, the job will be considered unsuitable. The Office did not consider the medical evidence from the claimant's psychiatrist prior to terminating compensation. The Board remanded the case for consideration of the medical evidence.

REFUSAL OF SUITABLE EMPLOYMENT - REFUSAL PRIOR TO SUITABILITY DETERMINATION

Migdalia Tirado, Docket No. 96-2303, Issued March 25, 1999

In this case, benefits were terminated by the Office under Section 8106(c)(2) on the grounds that the claimant refused an offer of suitable employment. On July 7, 1995 the employing agency offered the claimant a position as a modified distribution clerk. On July 20, 1995 the claimant refused the job offer on the grounds that the position required eight hours of standing. On July 28, 1995 the Office informed the claimant that this position was found suitable, was currently available and that the claimant had 30 days in which to accept the position or provide an explanation of her reasons for refusing it. No other reasons for refusal were received from the claimant. Therefore, on September 8, 1995, the Office terminated the claimant's compensation on the grounds that she had refused an offer of suitable work. for a hearing.

The Board found that the Office had improperly terminated the claimant's compensation benefits on the grounds that she had refused an offer of suitable employment. The Board held that the claimant offered her reasons for refusal on July 20, 1995 and the July 28, 1995 notice of suitability from the Office constituted only a preliminary determination. Once the Office finalized its determination of suitability, which was done in its September 8, 1995 decision, it did not provide the claimant with an opportunity to accept the position offered because the Office terminated her compensation at the same time.

Even though the claimant offered her reasons for refusal prior to the Office making a preliminary determination of suitability, i.e. the July 28, 1995 letter, the Office was still obligated to advise the claimant that her reasons for refusal were not deemed justified after finalizing the decision on the suitability of the job and to provide her with an opportunity to accept the job without penalty.

REFUSAL OF SUITABLE EMPLOYMENT-TEMPORARY EMPLOYMENT

Lethia M. Rollins, Docket No. 97-1759, Issued March 17, 1999

In this case, benefits were terminated by the Office under Section 8106(c)(2) on the grounds that the claimant refused an offer of suitable employment. On August 24, 1994 the employing agency offered the claimant a limited-duty position. On March 27, 1995 the Office informed the claimant that this position was found suitable based on a second opinion evaluation. On July 12, 1995, the Office terminated the claimant's compensation on the grounds that she had refused an offer of suitable work. The case was initially remanded by a hearing representative on the grounds that the limited duty job was temporary based on contact with the employing agency. The Office contacted the employing agency for clarification of the status of the offered limited duty position and, based on the response, again terminated the claimant's compensation.

The employing agency stated that the word "temporary" was used by the employing agency to distinguish between a limited duty job offer and a rehabilitation job offer. They further indicated that they had abandoned that practice at the request of this Office because it was confusing. However, the job was not temporary.

The Board held that, as the limited duty job offer was not temporary in nature, the Office properly terminated the claimant's compensation for failure to accept a suitable job offer.

RESCINDING ACCEPTANCE OF A CLAIM

Noah Ooten, Docket No. 96-1405, Issued March 12, 1999

In this case, the issue under consideration by the Board is whether the Office met its burden of proof to rescind acceptance of a claim for pneumoconiosis.

An occupational disease claim was filed alleging that the claimant developed coal workers' pneumoconiosis due to exposure to coal dust during his federal employment.

The Office arranged for him to be examined by an independent second opinion specialist. In a report dated April 12, 1994, the physician noted that chest x-rays read in the past noted interstitial changes compatible with pneumoconiosis and that the claimant had a 37-year history of mine work. He provided a diagnosis of coal workers' pneumoconiosis secondary to his federal employment. By letters dated April 25 and May 25, 1994 the Office requested the second opinion specialist to submit the results of current chest x-rays, as interpreted by a certified "B" reader, together with pulmonary function studies. In a June 8, 1994 report, x-rays taken on June 7, 1994 were read as revealing diffuse chronic interstitial lung disease consistent with coal worker's pneumoconiosis, type q/t, profusion of 1/1 affecting all six lung zones.

By letter dated November 16, 1994, the Office advised the claimant that his claim had been accepted for pneumoconiosis. The Office then processed his claim for a schedule award.

On August 21, 1995 the Office medical advisor noted that the second opinion physician did not submit the graphic results of any pulmonary function studies and noted that the record did not indicate whether the June 7, 1994 x-rays were reviewed by a certified "B" reader. Upon receipt of the pulmonary function studies and verification that the x-ray reviewer was a certified "B" reader, the Office medical advisor again reviewed the case and noted that the second opinion physician had indicated that the studies were effort dependent and were not representative of the claimant's best capabilities. The Office medical advisor further noted that the claimant made an erratic effort and showed poor cooperation with the testing process.

On September 15, 1995, the Office referred the claimant to a Board-certified pulmonary specialist and certified "B" reader. He opined that he saw no evidence of pneumoconiosis. He noted that the claimant's cooperation with the pulmonary testing was good and that his respiratory capacity was adequate to perform his previous occupation in the coal mining industry.

The Office found a conflict of medical opinion existed between the first independent medical examiner and the second independent medical examiner and referred the claimant for an impartial medical examination. By report dated February 9, 1996, this physician opined that the x-rays did not reveal a significant pulmonary condition or any evidence of occupational

pneumoconiosis.

By decision dated March 6, 1996, the Office rescinded its acceptance of the claim for pneumoconiosis and terminated compensation benefits.

The Board upheld the Office's decision noting that the Office had the authority to reopen a claim at any time on its own motion under section 8128(a) of the FECA and, where supported by the evidence, set aside or modify a prior decision and issue a new decision. The Board noted that, as always, the Office must justify rescission of acceptance of a claim by showing that it based its decision on new evidence, legal argument and/or rationale.

The Board noted that the Office was incorrect in determining that a conflict of medical opinion existed as both opinions were from Office referral physicians. However, the weight of the medical evidence rested with the final physician's opinion. The Board further noted that the Office had submitted new medical evidence addressing the relevant medical issue and, based on the weight of the medical evidence, properly reopened the claim and rescinded the acceptance of employment-related pneumoconiosis.

SCHEDULE AWARD - USE OF THE A.M.A. GUIDES

George H. Alexander, Docket No. 97-597, Issued January 5, 1999

The claimant's left foot and ankle injury on May 31, 1977 was accepted for left ankle sprain, and arthroscopy and meniscectomy of the left knee. On October 9, 1979, the Office made a schedule award for 65 percent permanent impairment of the left lower extremity. In 1993, the claimant submitted a medical report in support of a request for an increase in the schedule award. Based on that report and a review by the Office medical advisor, the Office determined that there was no increased schedule award.

The claimant again requested an increase in his award in 1994. He was advised to arrange for his physician to evaluate his impairment in accordance with the third edition of the A.M.A. Guides. A report was submitted which indicated that the claimant had 78 percent impairment of the left leg, based on the third edition of the Guides, and also requested authorization for an arthroscopy. Arthroscopy was authorized, and after surgery, the attending physician submitted another report. The report was reviewed by the Office medical advisor, who found a 73 percent impairment of the left lower extremity, based on the fourth edition of the A.M.A. Guides.

The Office subsequently asked the Office Medical Advisor to evaluate permanent impairment in accordance with the first edition of the A.M.A. Guides, stating that when a claimant seeks an increased award due to further deterioration without additional work exposure or injury, the edition of the A.M.A. Guides used should be the same as was used for the original award. The medical advisor found that there was 49 percent loss of use of the left lower extremity, in accordance with the first edition of the Guides. The Office issued a decision stating that the claimant was not entitled to an additional award. This decision was affirmed by a hearing representative and by reconsideration.

The Board also affirmed the decision, stating that the Office medical advisor properly applied the first edition of the Guides.

SCHEDULE AWARD FOR LUNGS - DATE OF INJURY PRIOR TO 1974

Johnnie Wilkins, Docket No. 97-241, Issued January 15, 1999

The Office accepted that the claimant contracted tuberculosis in 1965 due to exposure to a coworker. The last exposure occurred in 1965. He developed tuberculous bronchiectosis in 1993, consequential to his accepted tuberculosis.

In 1993, the claimant requested a schedule award for the lungs. The Office denied his claim on the basis that his exposure to the contributing work factors ceased prior to the 1974 amendments to the FECA, and no award for lungs was provided under the Act until the 1974 amendments.

The Board affirmed the Office's decision. The claimant argued that his permanent impairment was due to the consequential condition, and that since the consequential condition developed after the 1974 amendments, he should be eligible for a schedule award. However, the Board found that the original date of injury (which was 1965), not the date of the consequential injury, must be used to determine eligibility for the schedule award. Because the Act did not provide a schedule award for the lungs prior to 1974, the claimant was not entitled to such an award.

TERMINATING MEDICAL BENEFITS

Thomas A. Fekete, Docket No. 97-1279, Issued March 24, 1999

In this case, the issues under consideration by the Board are whether the claimant established a recurrence of disability and whether the Office met its burden of proof in terminating the claimant's medical benefits. The interesting decision in this case pertains to the termination of the claimant's medical benefits.

By decision dated September 5, 1996, the Office determined that the claimant had not established a recurrence of disability and that the claimant did not have continuing residuals of his employment injury. By decision dated November 18, 1996 this decision was modified to reflect entitlement to medical benefits through September 5, 1996 because he had received a letter from another district office advising him that his case was still open for medical treatment.

The Board upheld both decisions. With respect to the issue of continuing residuals the Board noted that there was no probative medical evidence indicating a continuing cervical or shoulder strain (the accepted medical conditions). A medical report from September 7, 1994 provided a diagnosis of minimal disc bulge at C6-7 but made no reference to a cervical or shoulder strain. There was no medical evidence after that until early 1996. A medical report from May, 1996 noted a spondylotic spur with a small herniated disc at C6-7. The neurosurgeon noted that this condition could have been aggravated by the work incident. However, as the conditions of spondylotic spur and herniated disc were not accepted as related to the work injury, it is the claimant's burden to prove that they were. The neurosurgeon's report is not sufficient to discharge that burden.

As there was no medical evidence indicating a continuation of the accepted medical conditions, the Board affirmed the Office's decision to terminate medical benefits.

TIMELINESS OF REQUEST FOR RECONSIDERATION OR HEARING

Benito A Perez, Docket No. 97-887, Issued January 7, 1999
Patricia A. Ingold, Docket No. 97-236, Issued January 4, 1999

Both of these decisions involve situations in which the claimant pursued appeal rights, the Office found that the request was not timely, and the Board set aside the Office's decision.

In Perez, the claim was originally denied on October 18, 1995. By fax on November 6, 1996, the Office received a copy of a request for reconsideration dated October 1, 1996. Along with the fax, the Office also received a copy of a receipt for certified mail, addressed to the Office, dated October 3, 1996. The Office denied reconsideration on November 15, 1996 as untimely, and lacking clear evidence of error.

The original letter dated October 1, 1996 was not found in the case file, nor was the envelope in which it was mailed. The Office did not consider whether the October 3, 1996 certified mail receipt was proof of timely filing for reconsideration, and the Board remanded the case.

In Ingold, the Office issued a denial decision on March 11, 1996. The claimant requested a hearing by letter dated April 10, 1996. The letter was not date stamped, and the envelope in which the letter was sent had not been retained in the file. The Office denied the request for hearing as untimely, stating that the request was postmarked April 11, 1996, which was more than 30 days after the March 11, 1996 decision.

The Board set aside the Office's decision, and directed the Office to produce evidence of the postmark date of the claimant's request. If the postmark could not be found, the request for a hearing would be considered timely.

WAGE EARING CAPACITY- ACTUAL EARNINGS

Thomas M. Demgen, Docket No. 96-2254, Issued February 9, 1999

In this case, the issue under consideration by the Board was whether the Office properly determined the claimant's wage earning capacity based on his employment as an industrial trainee. The claimant accepted the position of industrial trainee with his employing agency effective August 23, 1991 with retained pay. The job description for industrial trainee noted that the position was part of a FECA Development Program and consisted of assessment, career counseling, training/retraining, out placement counseling and ultimate placement into a career at the end of the program. The training program was slated to last from one month to two years. By decision dated June 29, 1995, the Office determined that the claimant's re-employment as an industrial trainee fairly and reasonably represented his wage earning capacity and that his compensation would be terminated since his actual wages met or exceeded the wages of the position held when injured.

The Board held that the Office improperly determined the claimant's wage earning capacity based upon his actual earnings as an industrial trainee. The Board noted that the Office's policy of determining that actual earnings represent a claimant's wage earning capacity can be invoked only in the absence of contrary evidence. In this case, the Board held that the evidence of record clearly indicated that the position of industrial trainee was temporary in nature because the job offer specifically stated the position would last from one month to two years. The fact that the job actually lasted well over two years did not alter the temporary nature of the position. Thus, the position of industrial trainee could not be considered suitable. The Office's decision on wage earning capacity was reversed.

WAGE EARNING CAPACITY-CONSTRUCTED POSITION

Diane M. Hackney, Docket No. 96-1078, Issued March 19, 1999

There were two issues before the Board in this claim. However, the issue of interest pertains to the decision on wage earning capacity. Compensation was reduced effective December 12, 1977 based on the Office's determination that the constructed position of general clerk constituted the injured worker's wage-earning capacity. That decision was subsequently vacated and a new constructed position of telephone solicitor was found to constitute her wage-earning capacity, again effective December 11, 1977. This decision was issued on October 17, 1983. The injured worker returned to work with her employing agency in a light duty capacity effective February 21, 1984 and again stopped work effective August 9, 1994 claiming that her current condition was a consequence of the May 21, 1975 work injury. By decision dated June 5, 1995, that claim was denied. Pursuant to the injured worker's request for reconsideration, the Office issued a decision on September 19, 1995 which modified the previous decision to the extent that the condition of agoraphobia was accepted as related to the May 21, 1975 work injury but that this condition had ceased on July 21, 1984.

The injured worker again requested reconsideration contending that, because agoraphobia was now an accepted condition, the wage-earning capacity decision was in error. By decision dated January 25, 1996, the Office denied modification of the prior decision.

The Board held that the Office failed to determine if the injured worker was capable of performing the duties of a telephone solicitor once they accepted the additional medical condition of agoraphobia. The claim was remanded for further evaluation of the evidence of record to determine whether the wage-earning capacity was in error and should be modified.

WEIGHING MEDICAL EVIDENCE

James Digiantommaso, Docket No. 97-1326, Issued March 24, 1999

In this case, the issue under consideration by the Board is whether the Office met its burden of proof in terminating the claimant's compensation. In determining the weight of the medical evidence, the Office relied on the medical opinion of an impartial medical examiner. The IME report indicated agreement with the opinions of the second opinion examiner but did not provide his reasons for doing so.

The Board held that, because the impartial medical examiner merely agreed with the opinions of the second opinion examiner without providing his own supporting rationale, his report was of diminished probative value and could not constitute a well-reasoned medical report. The Office's decision was, therefore, reversed.

FECA TRANSMITTALS (FT)--INDEX

FT 99-01 Revision to Chapter 4-0300, War Hazards (10/98A)

FT 99-02 Revision of FECA Program Memorandum 280, and of Chapter 2-0400, File Maintenance and Management, and Chapter 2-0402, Security and the Prevention of Fraud and Abuse (10/98A)

FT 99-03 Checklist, Federal (FECA) Procedure Manual (10/98A)

FT 99-04 Revision to Chapter 6-0300, Debt Liquidation, Part 6 - Debt Management, Federal (FECA) Procedure Manual (11/98A)

FT 99-05 Revision of Chapter 2-0808, Schedule Awards and Permanent Disability Claims, Chapter 2-0810, Developing and Evaluating Medical Evidence and 2-1700, Special Act Cases, Part 2 - Claims, Federal (FECA) Procedure Manual (11/98A)

FT 99-06 Revisions to Chapter 3-201, Staff Nurse Services, Chapter 3-700, Schedule Awards, and Chapter 3-900, Administrative Matters, Part 3 - Medical, Federal (FECA) Procedure Manual (11/98A)

FT 99-07 Revision to Chapter 2-1601, Hearings and Reviews of the Written Record, Part 2 - Claims, Federal (FECA) Procedure Manual (01/99A)

FECA TRANSMITTALS--TEXT

FECA TRANSMITTAL NO. 99-01 **October 5, 1998**

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

FECA TRANSMITTAL NO. 99-01 October 5, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 3 is updated to show the 1996, 1997, and 1998 yearly increases under the Longshore and Harbor Workers' Compensation Act.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

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

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

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

FECA TRANSMITTAL NO. 99-02 **October 5, 1998**

RELEASE - REVISION OF FECA PROGRAM MEMORANDUM 280, AND OF CHAPTER 2-0400, FILE MAINTENANCE AND MANAGEMENT, AND CHAPTER 2-0402, SECURITY AND THE PREVENTION OF FRAUD AND ABUSE, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 99-02 October 5, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

Program Memo 280 states that AUO (administratively uncontrollable overtime) pay is to be added as a percentage of basic pay in cases where the injury occurred after October 1, 1990. It

has been determined that AUO pay applies not only to pay rates based on date of injury, but also to those based on the date disability began and the date of recurrence. An addendum to this effect is being added to the Program Memo.

In PM 2-0400.12, the heading is corrected to refer to representatives.

In PM 2-0402.7, the reference to the ESA Manual of Administration is replaced by a reference to DLMS (Department of Labor Manual Series) 8. The ESA Manual no longer exists.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Program Memo 280			Program Memo 280		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0400	i, 11	2	2-0400	i, 11
	2-0402	i, 5-6		2-0402	i, 5-6

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

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

FECA TRANSMITTAL NO. 99-03 October 5, 1998

RELEASE -CHECKLIST, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 99-03 October 5, 1998

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 August 31, 1998. The previous checklist, issued September 30, 1997, and all transmittal sheets through No. 98-05 may be discarded. The current checklist should be retained at the front of the Procedure Manual, with transmittal sheets after No. 98-05.

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. 98-05			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. 99-04 October 30, 1998

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

FECA TRANSMITTAL NO. 99-04 October 30, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

Exhibit 1 is revised to show the debt collection interest rates for 1995-1998.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
6	6-0300	i Ex. 1 Ex. 2, p. 1	6	6-0300	i Ex. 1 Ex. 2, p. 1

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

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

FECA TRANSMITTAL NO. 99-05 November 17, 1998

RELEASE - REVISION OF CHAPTER 2-0808, SCHEDULE AWARDS AND PERMANENT DISABILITY CLAIMS, CHAPTER 2-0810, DEVELOPING AND EVALUATING MEDICAL EVIDENCE, AND 2-1700, SPECIAL ACT CASES, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 99-05 November 17, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

In PM 2-0808.7, the reference to PM 2-900.12 has been updated to PM 2-901.14.

In PM 2-0810.14(d), the second sentence currently states that if a claimant fails to attend a medical examination as directed by OWCP, compensation is suspended until the claimant appears for the examination. In fact, compensation is suspended until the refusal or obstruction stops, which is defined as the date on which the claimant agrees, either in writing or by telephone, to attend the examination. Compensation is restored retroactive to that date, but payment should not be certified until it has been verified that the claimant in fact did attend the examination.

For example, an examination is scheduled for May 1. The claimant states on March 15 that she will not attend. Compensation should be suspended effective March 15. The claimant telephones the office on April 5 and states that she will attend the examination after all. On May 1, after verifying that the claimant appeared for examination, compensation for the period April 5-May 1 may be certified.

The paragraph has been revised accordingly.

In PM 2-1700, Exhibit 1 has been updated to reflect the 1997 and 1998 increases in pay rates for Peace Corps and VISTA volunteers.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-0808	i, 7-8	2	2-0808	i, 7-8
	2-0810	i, 29-30		2-0810	i, 29-30
	2-1700	i, Ex. 1		2-1700	i, Ex. 1

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

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

FECA TRANSMITTAL NO. 99-06 November 5, 1998

RELEASE - REVISIONS TO CHAPTER 3-201, STAFF NURSE SERVICES, CHAPTER 3-700, SCHEDULE AWARDS, AND CHAPTER 3-900, ADMINISTRATIVE MATTERS, PART 3 - MEDICAL, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 99-06 November 5, 1998

EXPLANATION OF MATERIAL TRANSMITTED:

A new paragraph 15 addressing functional capacity evaluations has been added to PM 3-201. The material duplicates the content of PM 2-810.20.

Page 6 of PM 3-700 was inadvertently omitted from a previous printing and is added back into the chapter at this time. (The page is dated November 1998 since the actual date of issuance is unknown.) Current pages 6 and 7 have been renumbered 7 and 8.

A new paragraph 8 has been added to PM 3-900, stating the long-standing though informal policy within DFEC that no more than four hours of compensation or continuation of pay should be authorized for a routine medical appointment.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
3	3-0201	i, 21-22	3	3-0201	i, 21-23
	3-0700	i, 5-8		3-0700	i, 5-8
	3-0900	i, 7-8		3-0900	i, 7-8

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

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

FECA TRANSMITTAL NO. 99-07 January 4, 1999

RELEASE - REVISION TO CHAPTER 2-1601, HEARINGS AND REVIEWS OF THE WRITTEN RECORD, PART 2 - CLAIMS, FEDERAL (FECA) PROCEDURE MANUAL

FECA TRANSMITTAL NO. 99-07 January 4, 1999

EXPLANATION OF MATERIAL TRANSMITTED:

This chapter has been revised to modify the FECA procedures in accordance with the new Federal regulations which were approved and made final on November 25, 1998, and made effective on January 4, 1999. Upon review of the new regulations you will note that the part specifically pertaining to the Branch of Hearings and Review starts at § 10.615 and concludes at § 10.622. There are several changes which refer to extended deadlines for submitting requests, evidence or comments.

In paragraph 5 on Reviews of the Written Record, the number of days given to the employing agency to submit comments has been changed from 15 to 20 days, and the claimant's period for review and comment is increased from 15 to 20 days. Paragraph 6.a. is modified to allow 30 days instead of 15 between the date of mailing the hearing notice to the scheduled date of the hearing. Paragraph 6.b. refers to attachment CA-1127a (Exhibit 4) in which the period for comment on the hearing after release of the transcript is increased from 15 to 20 days. Similarly, paragraph 8.a. refers to the comment period for the employing agency after release of the transcript, and the fact the claimant has 20 days from the release of the comments to the claimant to review and comment as well. In paragraph 9 which discusses Cases Returned from H&R to the district offices, all references to Form CA-8 have been changed to Form CA-7.

However, the most important changes refer to the guidelines for requesting subpoenas, and the elimination of postponements except under the extraordinary circumstances specified in Section 10.622(c) of the new regulations. Paragraph 6.d. on Withdrawal and Postponement of Hearing Requests in Chapter 2-1601 has been rewritten to reflect the changes within the regulations at 20 CFR 10.622. Paragraph 6.e. of this chapter on Abandonment of Hearing Requests has also been rewritten to conform with this section of the regulations. Paragraph 6.e. of this chapter has been modified mainly to conform with the new deadline for requesting the subpoena of witnesses or documents for testimony or evidence at the oral hearing. Exhibits 2 through 6 are letters used by H&R which have been modified to reflect the changes in the various deadlines, and the more substantive changes regarding subpoenas, postponements, and withdrawal of and abandonment of hearing requests pursuant to the new regulations.

THOMAS M. MARKEY
Director for
Federal Employees' Compensation

FILING INSTRUCTIONS:

Remove Old Pages			Insert New Pages		
Part	Chapter	Pages	Part	Chapter	Pages
2	2-1601	i - 9	2	2-1601	i - 10
		Exs. 1 - 6			Exs. 1 - 6

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

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

OWCP BULLETINS (OB)--INDEX

OB 99-01 Resolving FECA Rehabilitation Cases Earlier by Streamlining the Rehabilitation Referral and Planning Process (04/99B)

OWCP BULLETINS--TEXT

OWCP BULLETIN NO. 99-01

Issue Date: April 9, 1999

Expiration Date: April 8, 2000

Subject: Resolving FECA Rehabilitation Cases Earlier by Streamlining the Rehabilitation Referral and Planning Process.

Background: To achieve the OWCP Strategic Plan goal of returning injured employees to work, the FY 1999 Federal Employees' Compensation program plan established a new goal of resolving Quality Case Management (QCM) cases within 30-months of the date disability began.

A *resolution* includes such outcomes as: reemployment, approval of a suitable training program for the injured worker, and formal determination of wage-earning capacity following vocational services. The OWCP rehabilitation program thus plays a central role in achieving this Federal Employees' Compensation program goal.

When Quality Case Management (QCM) procedures were established, the OWCP Rehabilitation Procedure Manual and "Red Book" (Counselor Resource Book) were revised to include stricter time requirements for referral of QCM cases to a Rehabilitation Counselor (RC), contacts by the counselor with the injured employee and employer, and receipt of an acceptable rehabilitation plan, if the employee did not return to work with the previous employer. Since active medical treatment, nurse efforts to obtain light duty, and second opinion evaluations can consume many

months before a QCM case reaches the Rehabilitation Specialist (RS), these rehabilitation time requirements will take on added importance in meeting the new goal.

Much time is consumed in OWCP rehabilitation cases by paperwork, waiting periods, and administrative processes. By streamlining preliminary steps, reducing paperwork, and insisting on prompt service delivery, time is gained for high quality vocational services.

Purpose: To streamline rehabilitation referral and planning procedures to meet program goals for reducing days lost due to disability.

Reference: VR Counselor Resource Book, p. 30; OWCP Procedure Manual 3-300.6b; 3-401 passim.

Applicability: OWCP Rehabilitation Specialists; FEC Supervisors.

Action:

A. Improve Referral Development

1. Rehabilitation Specialists should use the Rehabilitation Tracking System (N/RTS) "K/O Closure Reports" to identify cases which have been closed from nurse intervention services and which the CE may find are in posture for referral for vocational services. Reports closed code "K" by the Staff Nurse have work limitations on file. The RS should bring cases to the CE's attention which appear to be able to work full-time.

2. Cases should be opened for services promptly when referred and the directions and information given to the RC should be focused and complete. If a case comes from the CE with incomplete or contradictory work restrictions, the RS should make an effort to get resolution at the time of referral by discussing it with the CE face-to-face, so as to give the RC specific guidance, rather than leave it to the RC to interpret the medical information. If the discrepancy is not major, the CE may stipulate that the more restrictive work limitations be used as a basis for rehabilitation.

3. The RS should use judgement in sending medical reports to the RC. The RC must have the work tolerance limitations which were identified by the CE as the basis for a vocational rehabilitation effort, any reports explaining those limitations, and other medical information relevant to the vocational effort (such as a report describing a needed accommodation, or a fuller description of the accepted or concurrent medical conditions). Earlier reports in file which created a conflict of opinion, or which raise issues that were subsequently resolved by the CE may not be useful and should be omitted.

Nurse reports should be included when they contain relevant information- about the

injured worker's level of motivation, or approaches made to the employing agency, or the injured worker's background. The RS should be judicious in selecting medical and nurse reports which will focus the RC effort, not raise side issues.

If the RC is expected to pick up where the nurse left off with the employer, or to skip those contacts and move on, those instructions should be included in an OWCP-3 with the referral or inserted in the OWCP-35. The RS should give concrete direction to the RC and convey the expectation that the case will be handled timely, giving specific timeframes which you expect to be observed.

4. Enclose the injured employee's position description or SF-171, Optional Form 612 and/or resume' with the referral, if on file.

5. Each RS should review recent referral time frames to determine whether the quick turnaround required for QCM cases (five working days) is being met, and if not, make appropriate changes in the process so as to meet the time frames. The Accountability Review teams in FY 1999 will collect and share data on whether each office is meeting time frames.

6. The screening activity has been minimized in QCM cases. QCM cases must be referred for services or opened for functional capacity evaluation/work hardening unless there is some strong bar to referral in the judgement of the RS. To save time, the initial interview is optional in QCM cases if nurse reports are in file. Moreover, the guidelines in this bulletin require less copying of reports to further streamline referral.

This reduces the need for the professional services of contract screeners in recommending whether to open a case and conducting the initial interview. Screeners may be used in QCM cases *only* if there is an unusual volume of referrals which would otherwise not meet the five-working-day requirement. When used, screeners are required to meet that time frame.

B. Enforce Time Requirements on Counselors. The RS should take the following actions:

1. Review initial counselor reports to see if QCM time requirements for contacting the injured employee and employer are being observed. Reiterate the time frames in the outgoing Form OWCP-3, and issue a warning immediately if they are not observed. After a second warning, caseloads may be reduced. To accomplish this reduction, stop sending QCM cases to RCs who are not timely in initiating services.

2. Treat *Placement, Previous Employer* and *Plan Development* as a single period with a high level of services. In QCM cases, where work has already been done with the previous employer, two ninety-day periods should not be needed for these services. The RS should advise the RC in the OWCP-3 or OWCP-35 how much time is allotted for PPE/PD and state the date on

which a plan is required if the injured employee is not back at work with the previous employer. Enforce these time requirements with a warning if the plan is not on time (unless something exceptional has occurred to justify the delay).

Vocational evaluation should begin simultaneously with employer contacts, as soon as the case is opened. If testing is anticipated, it should be done in the first 30 days after referral. A transferable skills analysis should also be requested immediately. These tools can be helpful in thinking about reemployment opportunities with the Federal employer, getting the injured employee ready for the next step, and assessing the need for training.

3. Notify counselors in the region that, in keeping with national policy and Privacy Act considerations, you are using e-mail and fax to improve the quality and timeliness of service acquisition, and encourage (do not require) them to participate. Use e-mail or fax to alert RCs that a referral is coming and confirm their availability. Be sure that RCs are aware of the privacy rule that the injured employee is identified only by case number in the message. All e-mail communications with the RC should be printed and placed in the FECA case file.

C. Streamline the preliminary stages of the process.

1. The RS may authorize RCs to do their own vocational testing on QCM cases if they are able to provide good quality testing reports. Testing should be completed and evaluations submitted promptly.

2. The RS may waive testing if, based on reliable and documented information, the injured worker appears qualified for, e.g., training. The information could include past education and work experience, the results of the transferable skills analysis, a previous rehabilitation referral, or other documentation.

3. If the previous employer never provides light duty or the nurse has exhausted all potential, the RS should direct the counselor to move straight to planning and provide a plan within 90 days.

4. Be aware of the "lost production days" of each QCM referral and, within reason, modify planning time requirements to meet the goal. Give the RC a date on which the plan is due, and enforce timeliness.

Disposition: Retain until superseded or incorporated in the OWCP Procedure Manual.

Diane B. Svenonius

Director, Division of
Planning, Policy and Standards

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

OWCP CIRCULARS (OC)--INDEX

OC 99-01 Reimbursement Rates for Travel Effective April 1, 1999 (04/99B)

OWCP CIRCULARS--TEXT

OWCP CIRCULAR NO. 99-01 **April 1, 1999**

SUBJECT: Reimbursement Rates for Travel Effective April 1, 1999

Effective April 1, 1999 the rate for reimbursement to Federal employees traveling on official duty using privately-owned automobiles was decreased to 31 cents per mile by the General Services Administration. The rates for travel by motorcycle and airplane are not affected. As in the past, this rate has been made to apply to injured employees involved in approved rehabilitation activities (under the maintenance allowance and prior-authorized travel to and from a residential facility), and rehabilitation counselors and field nurses who are authorized to travel to provide services to injured workers.

Effective immediately all injured employees, counselors, and field nurses should be advised of the new rates in effect and date of applicability. Vouchers being processed for travel periods after April 1, 1999 may be adjusted to reflect this increase.

DIANE B. SVENONIUS
Director, Division of

Planning, Policy and Standards

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

OWCP TRANSMITTALS (OT)--INDEX

OWCP TRANSMITTALS--TEXT