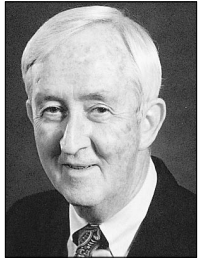




Osteoarthritis



Bert Doyle

Note: This article updates and replaces an article in the September 1987 *Postal Record*.

Osteoarthritis, or degenerative joint disease, is the most common form of arthritis; and it affects millions of people throughout the world. It can disable an employee for work, either because of an acute flare-up or on a long-time or permanent basis.

Arthritis is inflammation of the joint or joints. Osteoarthritis is characterized by degeneration of the articular cartilage—the thin layer of cartilage on the surface of bones where they join other bones. The bone itself and surrounding tissue can also be affected.

Osteoarthritis can affect all joints; the hands, feet, knees, hips and spine are common. The cartilage erodes or wears away and the result is pain, swelling, stiffness, deformity and limitation of motion.

There is no agreement in the medical community on the cause of osteoarthritis; and, consequently, there is much debate in individual workers' compensation cases.

Some physicians believe that osteoarthritis is due to normal wear and tear over a long period of time. There is evidence that some individuals are more susceptible than others—and that it is congenital. Some physicians believe that osteoarthritis is secondary to trauma or that trauma aggravates it. Some of the physicians who believe that trauma is an aggravating factor believe that only temporary aggravations occur, and that while a specific traumatic incident or series of incidents can aggravate or precipitate (i.e., bring forth from a dormant state) an episode of osteoarthritis—the trauma does not permanently affect the employee's underlying tendency to become arthritic.

The amount of trauma is also debatable. Is one incident of trauma competent to cause or aggravate osteoarthritis? More than one? How many incidents? Must there be many repeated incidents of trauma? Is the stress caused by hard work over the years competent to cause osteoarthritis—or aggravate, accelerate (i.e., hasten) or precipitate it?

The Office of Workers' Compensation Programs has accepted osteoarthritis claims due to trauma, or (less frequently) working conditions over a long period of time.

Claims may be accepted based on a finding that only a temporary aggravation occurred—i.e., an employee suffered a strain which aggravated the employee's underlying degenerative joint disease—but the aggravation ceased after four to six weeks. Compensation benefits also cease in such cases, and any continued pain and disability is attributed to

the underlying disease—and not to the strain.

Many claims are also denied—principally because of a lack of competent and probative medical evidence, as OWCP and the Employees' Compensation Appeals Board like to put it.

In essence, the burden of proof is on the employee; however, a mere medical report from a physician stating that the employee's injury or employment caused the osteoarthritis—or aggravated it—is not sufficient.

The medical evidence must be in the form of a detailed narrative medical report, preferably from a board-certified orthopedic surgeon, containing (in addition to dates of examination and treatment, description of tests given, results of x-ray, etc.) five key items:

1. A written statement by the physician reflecting knowledge of the employee's injury or conditions of employment believed to be the causative factor(s). The physician should ideally include or attach a copy of a written statement prepared by the employee describing the injury or conditions of employment; and should reference the employee's statement with remarks such as: "I have read the statement dated _____, prepared by _____, regarding the injury sustained on _____ and/or the conditions of employment at _____ during the period from _____ to _____."

2. Definitive (i.e., conclusive) diagnosis (*no impressions*).

3. Opinion in definitive (i.e., conclusive) terms (*no speculation*): Was condition caused, permanently or temporarily aggravated, accelerated (hastened), or precipitated by the injury and/or the conditions of employment described by the employee? If only a temporary aggravation, acceleration or precipitation—then the opinion must specify the length of time involved.

4. Medical reasons for opinion (i.e., how did the physician, from a medical point of view, arrive at the opinion?). This is *very important* and should include a discussion of the pathological or other medical relationship between the diagnosis and the injury or conditions of employment and an explanation of how any test results formed a basis for the opinion.

5. Period(s) of disability and the extent of disability during the period(s). This should specify whether the disability is total or partial, and if partial (as opposed to total disability for work as a letter carrier), the work limitations involved in working while partially disabled.

An employee must keep in mind that unless the physician fully and positively supports the claim and provides medical reasons for the medical opinion rendered (otherwise known as *medical rationale*), the claim will very likely fail (see articles in the May and June 1996 issues of *The Postal Record* for further information concerning the importance of medical rationale). ☒

Bursitis and tendinitis/tenosynovitis



Bert Doyle

Note: This article updates and replaces an article in the May 1989 issue.

Two disabling conditions often seen in workers' compensation claims are bursitis and tendinitis/tenosynovitis—painful inflammations of portions of the body that are in daily use.

Bursitis refers to inflammation of a bursa, one of numerous flattened sacs or saclike cavities filled with a thick oil-like fluid that are situated at places in the body where friction would otherwise develop. Bursae act as protective pads between adjacent areas of moving tissues, thereby preventing the tissue surfaces from moving against each other. Most bursitis occurs in the shoulder but other forms exist—such as in the elbow, knee or big toe.

Tendinitis refers to inflammation of an enclosed tendon and **tenosynovitis** to inflammation of the tendon sheath. Tendons are fibrous cords which form the end of a muscle and which connect the muscle to the bone (i.e., the muscle tissue gradually merges with another kind of tissue, tendon tissue, which forms the attachment to the bone). Tendinitis and tenosynovitis can occur simultaneously—and affect such sites as the shoulder, elbow, wrist, hip, knee and foot (Achilles tendon).

Bursitis and tendinitis/tenosynovitis may be the result of an acute or chronic infection—or may be the result of trauma or strain, usually repeated trauma or strain, or excessive motion of some type. The bursitis or tendinitis/tenosynovitis may be acute, resolving with rest and medication, or may be chronic (particularly when associated with calcified deposits).

The Office of Workers' Compensation Programs has accepted numerous bursitis and tendinitis/tenosynovitis claims—most often on the basis of repeated trauma or strain or working conditions over a long period of time.

Claims are usually accepted on the basis that the condition is temporary (i.e., the condition will not continue for more than a few weeks). In instances where the condition is chronic, OWCP may only accept that the employment caused a temporary aggravation for a set period of time (i.e., four or six weeks).

Many claims are also denied—principally because of a lack of competent and probative medical evidence, as OWCP and the Employees' Compensation Appeals Board like to put it.

In essence, the burden of proof is on the employee; however, a mere medical report from a physician stating that the employee's injury or employment caused the bursitis or tendinitis/tenosynovitis—or aggravated it—is not sufficient.

The medical evidence must be in the form of a detailed narrative medical report, preferably from a board-certified orthopedic surgeon, containing (in addition to dates of examination and treatment, description of tests given, results of x-ray, etc.) five key items:

1. A written statement by the physician reflecting knowledge of the employee's injury or conditions of employment believed to be the causative factor(s). The physician should ideally include or attach a copy of a written statement prepared by the employee describing the injury or conditions of employment; and should reference the employee's statement with remarks such as: "I have read the statement dated _____, prepared by _____, regarding the injury sustained on _____ and/or the conditions of employment at _____ during the period from _____ to _____."

2. Definitive (i.e., conclusive) diagnosis (*no impressions*).

3. Opinion in definitive (i.e., conclusive) terms (*no speculation*): Was condition caused, permanently or temporarily aggravated, accelerated (hastened), or precipitated by the injury and/or the conditions of employment described by the employee? If only a temporary aggravation, acceleration or precipitation—then the opinion must specify the length of time involved.

4. Medical reasons for opinion (i.e., how did the physician, from a medical point of view, arrive at the opinion?). This is *very important* and should include a discussion of the pathological or other medical relationship between the diagnosis and the injury or conditions of employment and an explanation of how any test results formed a basis for the opinion.

5. Period(s) of disability and the extent of disability during the period(s). This should specify whether the disability is total or partial, and if partial (as opposed to total disability for work as a letter carrier), the work limitations involved in working while partially disabled.

An employee must keep in mind that unless the physician fully and positively supports the claim and provides medical reasons for the medical opinion rendered (otherwise known as *medical rationale*), the claim will very likely fail (see articles in the May and June 1996 issues of *The Postal Record* for further information concerning the importance of medical rationale). ☒

Time limitations for notice and claim



Bert Doyle

Note: This article updates and replaces articles in the December 1986 and January 1987 issues.

The Federal Employees' Compensation Act requires that an employee give written notice of injury or occupational disease and file claim for compensation within specified time periods. If the employee fails to meet the appropriate time limitations, the claim will be denied

even if it is otherwise valid.

These limitations do not apply to:

- A minor, until he or she reaches age 21 or a legal representative is appointed.

- An incompetent individual while he or she is incompetent and has no duly appointed legal representative.

Traumatic injury: An employee, or someone acting on the employee's behalf, is required to give his or her supervisor written *notice* of traumatic injury within 30 days after an on-the-job injury. OWCP has made Form CA-1, "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," available for this purpose.

Since a traumatic injury can be identified as to time, place and circumstances, time begins to "run" or start from the actual date of injury.

If a notice of traumatic injury is not filed within 30 days, the employee loses the right to receive continuation-of-pay (COP) benefits; however, the employee is entitled to claim compensation benefits for the period that the lost COP would have covered provided the time requirement for filing written *claim* is met.

In this respect, and in addition to providing written notice, an employee, or someone acting on the employee's behalf, is required to file written *claim* for compensation within three years from the actual date of injury. However, if the supervisor had actual knowledge of the injury, or if written notice of the injury was given within 30 days, the time requirement for a claim for compensation will be met.

Information addressing the issue of the supervisor's actual knowledge is applicable only when the supervisor did not receive written claim within three years. This knowledge must place the supervisor reasonably on notice that an on-the-job injury occurred; and OWCP has held that the supervisor may acquire actual knowledge, through firsthand observation of the injury, from another employee or from medical personnel at the agency's medical facility. An entry into the employee's medical records may also be considered proof of actual knowledge.

OWCP has designed Form CA-1 so that it (through use of

words of claim) meets the written claim requirement of the FECA—as well as the notice of traumatic injury requirement.

Occupational disease: As in a traumatic injury, written *notice* of occupational disease must be given within 30 days. OWCP has made Form CA-2, "Federal Employee's Notice of Occupational Disease and Claim for Compensation," available for this purpose. Form CA-2, like Form CA-1, is designed so that it meets both the notice and claim requirements of the FECA.

There is no "penalty" for failure to file written *notice* of occupational disease within 30 days, as COP benefits are not payable in occupational disease cases. As in a traumatic injury, written *claim* must, however, be filed within three years—or compensation benefits will be denied.

Time, in an occupational disease case, begins to run or start when the employee is aware, or by the exercise of rea-

¶ If the employee fails to meet the appropriate time limitations, the claim will be denied even if it is otherwise valid. ¶

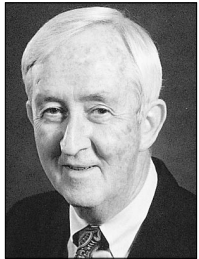
sonable diligence should have been aware, of the disease and its causal relationship to the employment.

In many situations time begins to run when a physician tells the employee that he or she has a disease which may be work-related. However, in situations where the employee continues to be exposed to injurious employment conditions, time does not begin until the last date of such exposure.

If the disease results in a latent disability—i.e., one that does not show outward appearances until some time after (usually long after) the employment conditions are over (e.g., asbestosis caused by exposure to asbestos)—then time does not run until the employee has a compensable disability and is aware, or by the exercise of reasonable diligence should have been aware, of the causal relationship of the compensable disability to his or her employment.

Exceptional circumstances: The requirement for filing claim in traumatic injury or occupational disease cases may be excused by OWCP on the grounds that the claim "could not be given because of exceptional circumstances." The only example of this published by OWCP is an employee held prisoner overseas by a foreign power for the entire three-year period. ☒

Avoid errors/omissions after on-the-job injuries



Bert Doyle

Note: This article updates and replaces an article in the March 1988 issue.

Errors and/or omissions or lack of knowledge of proper procedure when first reporting an on-the-job injury or in obtaining initial medical treatment can play havoc with a claim for continuation of pay (COP) or compensation benefits.

The havoc can be so great as to taint the claim forever—with no amount of subsequent explanation or evidence sufficient to overcome the initial mistakes.

Like it or not, an employee's credibility with the Postal Service and the Office of Workers' Compensation Programs is at stake when a notice of injury or occupational disease is filed. Much can be done, however, to reinforce credibility and to avoid problems if the following relatively simple steps are taken:

1. Have a physician in mind *before an injury occurs*. An injured employee has the right to the initial choice of a treating physician (following any necessary emergency treatment) generally within 25 miles of his or her home or place of employment.

The physician should be one you can relate to, have confidence in, and one who does not mind the paperwork involved. The important thing to remember is that the employee has the right of initial choice. Once a choice is made, the employee cannot change physicians without OWCP's approval.

2. Make a verbal report of the injury to an appropriate Postal Service supervisor *as promptly as possible* (preferably within minutes or hours) and make every effort to obtain and complete OWCP's Form CA-1, Federal Employee's Notice of Injury and Claim for Continuation of Pay/Compensation, *on the day of injury*—or at least within two days.¹

3. Obtain medical treatment *as soon as possible*—preferably on the date of injury. Reporting an injury and/or receiving treatment several days after the injury may undermine an employee's credibility—leading the Postal Service and OWCP to question the claim. Take steps to ensure that OWCP's Form CA-16, Authorization for Examination and/or Treatment, is promptly issued to your choice of physician.²

4. Provide the physician with full information regarding the *cause of injury* and be sure to describe *all* parts of the body affected by the injury. Take pains to ensure that the history and description of the injury furnished to the physician are *identical* to that reported to the Postal Service and OWCP (see following two items).

5. Be very specific and furnish *all details* regarding the cause of injury when completing Form CA-1. An injury reported as "Fall on ice" is not as descriptive as "My right foot slipped out from under me while descending icy porch steps. This caused me to twist violently to the left and to fall down the remaining five steps. I landed on my back with my right arm under me."

6. Be equally specific regarding the nature of injury—the words "Back and hand injury" for the above cause of injury are not as helpful (or protective should subsequent problems arise) as "Contusion of left buttock and left shoulder; back strain; and abrasions and swelling, right hand and thumb."

7. Provide the names of any witnesses and take steps to ensure that written statements are obtained from the witnesses describing what they saw, heard or know about the injury. Note that there is a space for one witness statement on Form CA-1—following the end of the employee's report.

8. Be certain that you exercise your right to the choice of receiving COP as opposed to using sick or annual leave when completing Form CA-1 (COP should be chosen in virtually all instances). *Contact a knowledgeable NALC branch*

« Much can be done to reinforce credibility and avoid problems. »

officer or your national business agent immediately if there is any problem in obtaining COP—or in obtaining treatment from a physician of your choice.

9. Obtain a completed receipt for the Form CA-1. There is a tear-off receipt on every Form CA-1 which the receiving Postal Service official must immediately complete and return to the employee.³

10. Know that *you* are responsible for ensuring that the Postal Service and OWCP receive timely medical evidence from your physician in support of your claim—and know that *you* have certain obligations to inform your physician regarding your return to duty and the availability of alternative work and other forms of limited duty. *More on this in a subsequent issue.* ☒

1. Form CA-1 must be filed within 30 days to obtain COP.
2. OWCP's regulations specify that Form CA-16 shall be issued within four hours.
3. A similar receipt is on every Form CA-2, Federal Employee's Notice of Occupational Disease and Claim for Compensation.

Occupational disease or illness claims



Bert Doyle

Note: This article updates and replaces an article in the February 1991 issue.

The Office of Workers' Compensation Programs defines an "occupational disease or illness" as a medical condition produced in the work environment *over a period longer than a single workday or shift* by such factors as systemic infection; continued or repeated stress or strain; or exposure to hazardous elements such as, but not limited to, toxins, poisons, fumes, noise, particulates or radiation, or other continued or repeated conditions or factors of the work environment.

A claim based on an occupational disease is filed with OWCP on Form CA-2, "Federal Employee's Notice of Occupational Disease and Claim for Compensation"—and it must be kept in mind that the *employee* has the burden of proving that the occupational disease is causally related to the employment (survivors have the same burden in death cases).

The term "causally related," as used in workers' compensation, means "proximately caused"—and "proximately caused" is recognized to mean *closely related, as a result of, or following—in addition to direct cause*.

As a general rule, a claim based on an occupational disease is considerably more difficult to prove than a claim based on a traumatic injury; and to be successful in pursuing a claim with OWCP, an employee must provide two basic documents:

■ **Factual statement**—A detailed statement, dated and signed by the employee, describing the conditions or factors of employment believed to be the cause of the occupational disease—and the period of time involved. Depending on the specific claim being made, the statement should include such items as the length and description of routes, number of stops, temperature and/or other weather conditions, number of mail bags lifted per day, average weight of mail bags, nature and origin of toxins, etc. A description of the *specific* duties of the employee making the claim is of more value than a general description of duties.

■ **Medical report**—A detailed *narrative* medical report from the employee's attending physician—dated and signed on the physician's stationery and containing (in addition to dates of examination and treatment, descriptions of tests given, results of x-rays, etc.) the following *five* key items:

1. A written statement by the physician reflecting knowledge of the employee's conditions of employment believed to be the cause of the claimed medical condition and result-

ing disability. The physician should ideally include or attach a copy of a written statement prepared by the employee describing the conditions of employment; and the physician should reference the employee's statement with opening remarks such as:

"I have read the statement dated _____ prepared by _____ regarding the conditions of employment at _____ during the period from _____ to _____."

2. Definitive (i.e., conclusive) diagnosis (*no impressions*).
3. Opinion in definitive (i.e., conclusive) terms (*no speculations*): Was diagnosis caused, permanently or temporarily aggravated, accelerated (hastened), or precipitated by the conditions of employment described by the employee? If only a temporary aggravation, acceleration or precipitation—then the opinion must specify the length of time involved.

4. Medical reasons for opinion (i.e., how did the physician, from a medical point of view, arrive at the opinion?). This is *very important* and should include a discussion of the pathological or other medical relationship between the diagnosis and the conditions of employment and an explanation of how any test results formed a basis for the opinion.

5. Period(s) of disability and the extent of disability during the period(s). This should specify whether the disability is total or partial, and if partial (as opposed to total disability for work as a letter carrier), the work limitations involved in working while partially disabled.

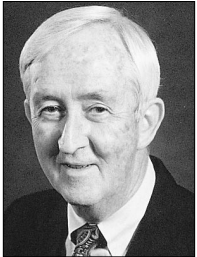
Frame of reference: As will be noted from the above, the factual statement and medical report are related. Without the factual statement, the physician does not have a proper "frame of reference" for his or her medical opinion—and many claims fail because a physician has furnished a medical report that does not reflect (see item 1 above) full knowledge of the conditions of employment.

Positive medical opinion: Many claims also fail because the diagnosis and/or medical opinion (items 2 and 3 above) are not provided in positive terms. A speculative diagnosis is worthless, as is a medical opinion couched in wishy-washy language (i.e., terms such as "might be related" or "could very possibly be related" are of no value).

Medical rationale critical: Finally, unless medical rationale is provided by the physician (item 4 above), adjudication of the claim will be delayed until OWCP is satisfied that a full explanation of the basis of the physician's medical opinion is in the case record—or the claim will in all probability fail.

Further information on causal relationship and medical rationale is provided in Compensation Department articles in the March through June 1996 issues of *The Postal Record*. ☐

Understanding compensation benefits



Bert Doyle

Note: This article updates and replaces an article in the February 1987 issue.

With one exception (schedule awards), benefits of the Federal Employees' Compensation Act are not payable unless the injured employee sustains disability for work.

Assuming that a traumatic injury occurred and that the injury was properly reported within 30 days, then the employee is entitled to continuation-of-pay (COP) for wage loss as a result of the injury—up to 45 calendar days, either consecutively or intermittently.¹

If the period of wage loss due to a traumatic injury lasts beyond 45 days, then the employee may claim compensation benefits. Compensation benefits begin on the 46th day, subject to a three-calendar-day waiting period. The waiting period is waived, however, if the period of wage loss exceeds 14 calendar days or if the Office of Workers' Compensation Programs determines that the employee has a permanent disability. As a general rule, compensation benefits beginning at the end of the 45-day COP period are payable because the employee is still under active medical care and the physician considers the employee disabled for work as a result of the injury.

If the employee is disabled for the work performed at the time of injury but is not disabled for all work, then the Postal Service may offer limited duty which the employee cannot refuse without loss of compensation benefits—provided OWCP determines that the limited duty is suitable to the employee's disability.²

A finding of permanent disability is not made until the attending physician advises OWCP that maximum medical improvement, sometimes referred to as maximum healing, has been reached. If the disability involves loss or loss of use of certain statutorily scheduled members, then OWCP will provide for payment of a schedule award for such loss or loss of use.

Unlike compensation benefits for wage loss, a schedule award has no direct relationship to the employee's loss of earnings; the award is made to compensate the employee for the permanent physical impairment caused by the injury.³

Compensation for wage loss is not paid during the period of time covered by a schedule award (e.g., a schedule award for 20 percent loss of use of a leg is paid over a period of 57.6 weeks beginning on the date of maximum medical improve-

ment whether or not the employee has returned to work).

If the permanent disability does not permit payment of a schedule award (e.g., a back injury which does not cause loss of use of a scheduled member) and the employee has not returned to work (whether or not OWCP made efforts to assist the employee in returning to work), then OWCP will establish an earning capacity and reduce the employee's compensation accordingly.

Being disabled for *all* work means just that—the results of the injury are so severe that the employee cannot perform *any type of remunerative employment*.

If OWCP determines that the injury-related disability, combined with the employee's age and other factors (including any medical conditions that *pre-existed* the injury), is so severe as to disqualify the employee for all work, then the compensation will not be reduced.

In this respect, the great majority of injuries involving permanent disability do not prevent the employee from returning to some kind of work. The FECA recognizes this and provides for reduced compensation benefits when the medical evidence shows that an employee is no longer totally disabled—but has a permanent *partial* disability. The FECA also prescribes the method for determining a partially disabled employee's earning capacity—essentially involving OWCP's selecting a job that best represents the employee's earning capacity in his or her partially disabled condition. Reduced benefits are then paid on the basis of this OWCP-determined earning capacity.

Establishment of an employee's earning capacity is a complicated procedure and must take into consideration the employee's injury-related disability, any existing disability that *preceded* the injury, and such other factors as the employee's age, education, experience and geographical location.⁴

Whether or not OWCP is compensating an employee on the basis of total disability or on the basis of an earning capacity determination, periodic medical reports will be required by OWCP from either the employee's attending physician, or (at OWCP's option) a physician designated by OWCP. The employee must cooperate in this—under penalty of loss of compensation benefits. ☒

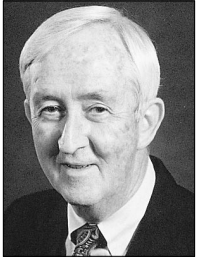
1. COP is not applicable in occupational disease cases or when notice of traumatic injury on Form CA-1 is not filed within 30 days. Employees are, however, entitled to claim applicable compensation benefits in such situations.

2. Specific provisions for offering limited duty are contained in 546.141 of the Postal Service's *Employee and Labor Relations Manual*. See also NALC Compensation Department articles in the May through August 1997 issues of *The Postal Record*.

3. For full listing of scheduled members, organs and functions, plus a discussion on schedule awards, see articles in the February and March 1995 issues of *The Postal Record*.

4. For a full discussion on earning capacity determinations see articles in the October 1991 through January 1992 issues of *The Postal Record*.

Proving causal relationship—reprise



Bert Doyle

More than any other reason, claims under the Federal Employees' Compensation Act are denied because of a lack of rationalized medical evidence based on an accurate history establishing that the disability claimed is causally related to the claimed injury or conditions of employment.

This has been the subject of previous Compensation Department articles, most recently a series of articles in the March through June 1996 issues of *The Postal Record*—and this article reprises the April 1996 article that stressed the need for obtaining the right kind of medical evidence.

There are five critical items which *must* be included in the medical evidence supporting all but the most obvious claim filed with the Office of Workers' Compensation Programs. Because the burden of proof is on the employee, the employee must ensure that these items are provided by his or her attending physician (preferably an appropriate medical specialist).

OWCP forms designed for obtaining medical evidence in instances of a routine traumatic injury, such as OWCP Form CA-20, will not suffice for these claims—the medical evidence *must* be in the form of a narrative medical report, dated and signed on the physician's stationery (and including dates of examination and treatment, description of tests given, results of x-rays, etc.) as follows:

1. A written statement by the physician reflecting knowledge of the employee's injury or conditions of employment believed to be the cause of the claimed medical condition and resulting disability. The physician should ideally include or attach a copy of a written statement prepared by the employee describing the injury or conditions of employment; and the physician should reference the employee's statement with opening remarks such as:

■ "I have read the statement dated _____ prepared by _____ regarding the injury sustained on _____."

or (if applicable):

■ "I have read the statement dated _____ prepared by _____ regarding the conditions of employment at _____ during the period from _____ to _____."

2. Definitive (i.e., conclusive) diagnosis (*no impressions*).

3. Opinion in definitive (i.e., conclusive) terms (*no speculation*): Was diagnosis caused, permanently or temporarily

aggravated, accelerated (hastened), or precipitated by the injury of conditions of employment described by the employee? If only a temporary aggravation, acceleration or precipitation—then the opinion must specify the length of time involved.

4. Medical reasons for opinion (i.e., how did the physician, from a medical point of view, arrive at the opinion? This is *very important* and should include a discussion of the pathological or other medical relationship between the diagnosis and the injury or conditions of employment and an explanation of how any test results formed a basis for the opinion.

5. Period(s) of disability and the extent of disability during the period(s). This should specify whether the disability is total or partial, and if partial (as opposed to total disability for

There are five critical items which must be included in the medical evidence supporting all but the most obvious claim filed with OWCP.

work as a letter carrier), the work limitations involved in working while partially disabled.

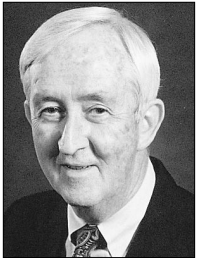
Many claims fail because a physician's medical report does not contain all of the above items—the first one necessary in order to prove to OWCP that the physician has been provided with an accurate "frame of reference" for his or her opinion.

The second and third items must be provided in positive terms—a speculative diagnosis is worthless, and medical opinions containing words such as "might be related" or "could possibly be related" are speculative and of no value.

Finally, and excepting cases where the causal relationship is obvious, unless the fourth item (medical rationale) is provided, adjudication of the claim will be delayed until OWCP is satisfied that a full explanation of the basis of the physician's medical opinion is in the case record—or the claim will in all probability fail.

Additional information on medical rationale is provided in the May and June 1996 issues of *The Postal Record*. ☐

Traumatic injury vs. occupational disease/illness



Bert Doyle

Note: This article updates and replaces an article in the May 1992 issue.

Recent correspondence and discussions with national business agents and branch officers indicate that members often receive wrong information and/or advice from postal supervisors concerning the distinction between a traumatic injury and an occupational disease or illness.

There is a distinction and proceeding in the wrong direction with the wrong initial notice and claim form can cause serious delays and other problems.

Prior to the 1974 Amendments to the Federal Employees' Compensation Act, the issue of whether a medical condition was due to a traumatic injury or an occupational disease or illness was relatively unimportant with regard to filing a claim for benefits.

The Amendments changed this by establishing the unique concept of continuation-of-pay (COP)—payable for up to 45 calendar days as a substitute for compensation benefits. COP is applicable *only* to traumatic injuries, and was created primarily because of long delays in the submission of necessary notice and claim forms to the Office of Workers' Compensation Programs.

OWCP was therefore required to define "traumatic injury" for COP purposes—and has done so in its official regulations for administering the FECA as follows:

*"Traumatic injury" means a wound or other condition of the body caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected. The injury must be caused by a specific event or incident or series of events or incidents within a single work day or work shift.*¹

Stated simply, a traumatic injury for OWCP purposes is a wound or other condition of the body caused by an external force—including stress or strain. It must occur at a specific time and place; affect a specific part or function of the body; and be caused by a specific incident or series of incidents occurring within a single work day or shift.

Once one understands OWCP's definition of traumatic injury, the definition of occupational disease or illness is easy—inasmuch as an OWCP occupational disease or illness is, practically speaking, any condition that does not meet OWCP's definition of traumatic injury.

From a formal definition standpoint, an occupational disease or illness for OWCP purposes is a medical condition produced in the work environment *over a period longer than a single work day or shift* by such factors as systemic infection; continued or repeated stress or strain; or exposure to hazardous elements such as, but not limited to, toxins, poisons, fumes, noise, particulates or radiation, or other continued or repeated conditions or factors of the work environment.²

Stated another way, an OWCP occupational disease or illness is a medical condition related to factors in the workplace occurring beyond a single work day or shift.

With this in mind, a heart attack (myocardial infarction) can be classified by OWCP as either a traumatic injury or an

There is a distinction and proceeding with the wrong initial notice and claim form can cause serious delays and other problems.

occupational disease or illness, depending on the causative factors involved (e.g., if due to one day's overexertion in hot weather, it is classified as a traumatic injury; if due to several days or weeks of such overexertion, it is classified as an occupational disease or illness).

Similarly, a muscle strain is a traumatic injury if due to one lifting incident or several incidents during one day or shift; and is classified as an occupational disease or illness if due to repeated lifting that extends beyond one day or shift (i.e., over two or more days' time).

The bottom line is that the *cause* of the medical condition dictates whether OWCP classifies it as a traumatic injury or an occupational disease or illness—and this then dictates whether Form CA-1 or CA-2 is filed.³

1. 20 CFR 10.5(a) (15).

2. 20 CFR 10.5(a) (16).

3. Form CA-1, entitled "Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation," is used for a traumatic injury; and Form CA-2, entitled "Federal Employee's Notice of Occupational Disease and Claim for Compensation," is used for an occupational disease or illness.

OWCP overpayments



Bert Doyle

Note: This article updates and replaces articles in the January 1981 and November 1986 issues.

The Federal Employees' Compensation Act provides that when an overpayment of compensation benefits has been made to a payee because of an error of fact or law, the Office of Workers' Compensation Programs shall recover the amount of the overpayment—except that “when incorrect payment has been made to an individual who is without fault,” recovery of the overpayment may be waived by OWCP when the recovery “would defeat the purpose of the Act or would be against equity and good conscience.”

Overpayments occur for a variety of reasons—some are usually considered to be the fault of the payee receiving them (e.g., failure to report return to work or change in status of dependents) and others are the fault of OWCP (e.g., payment of compensation following receipt of report of return to work or change in status of dependents, failure to terminate benefits at the expiration of a schedule award, and improper application of cost-of-living increases).

Overpayments also occur when an employee-payee fails to report earnings—and is required to forfeit all compensation paid for the affected period. The employee is considered at fault in such situations and very serious if not devastating problems can occur, including charges of fraud.²

It is important to note that even when OWCP is clearly at fault, the payee may not be “without fault”—and therefore ineligible for a waiver of the overpayment.

In this respect, the Department of Labor's Employees' Compensation Appeals Board has established that in determining whether an individual is “without fault,” what constitutes “fault” depends on whether the facts show the incorrect payment resulted from:

- (a) *An incorrect statement made by the payee which the payee knew or should have known to be incorrect.*
- (b) *Failure of the payee to furnish information which the payee knew or should have known to be material; or*
- (c) *Acceptance of a payment which the payee either knew or should have been expected to know was incorrect.*³

Many overpayments fall into category (c) above—including payments made for a period after a payee reported that he

or she had returned to work or reported a change in the status of his or her dependents; and should OWCP find *that the payee was aware or reasonably should have been aware that the compensation benefits were in error*, then the payee is *not* “without fault”—and OWCP will refuse to consider a request for waiver of the overpayment.

Waiver is also not automatic in instances where OWCP determines that the payee is without fault—OWCP having considerable discretion to grant waiver based on one of two statutory criteria: “defeat the purpose of the Act” or “against equity and good conscience.”

The term, “defeat the purpose of the Act” means defeat the purpose of benefits under the FECA, i.e., to provide at least a subsistence income for beneficiaries. This depends upon whether the payee has an income or financial resources sufficient for more than ordinary needs, or is largely or solely dependent upon the current payment of OWCP's benefits for the necessities of life.

The term “against equity and good conscience” has been defined to include situations where the payee would experience severe financial hardship in attempting to repay the overpayment; or where the payee has relinquished a valuable right or changed his or her position for the worse in reliance on the compensation benefits being received from OWCP.

If OWCP determines that an employee was at fault, Form CA-2201 is sent explaining the overpayment and why it is believed that the employee was at fault. If the employee was not at fault, Form CA-2202 is sent. Both of these notifications explain the waiver of overpayment provisions of the Act and provide the right to submit, *within 30 days* of the notification, either: (1) additional written evidence and/or argument; or (2) a request for a pre-recoupment hearing.

Recoupment (collection) of an overpayment does not begin until a final decision is issued by OWCP at the end of this 30-day period—or after a requested pre-recoupment hearing.

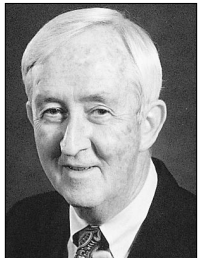
Final OWCP decisions on overpayments are not subject to the hearings and reconsideration provisions of the Act (even though a pre-recoupment hearing was not previously requested), but can be appealed to the ECAB. Recoupment actions are not delayed by such an appeal. ☒

1. 5 USC 8129(a) and (b).

2. See article on “Reporting Employment to OWCP” in the October 1994 issue.

3. *Wanda L. Brown*, 33 ECAB 1133, 1982 (and other cases).

Recurrences of disability



Bert Doyle

Note: This article supplements an article in the June 1995 issue of *The Postal Record* on the subject of recurrences vs. new injuries/illnesses.

A recurrence of disability, as defined by the Office of Workers' Compensation Programs, is a work stoppage caused by:

■ A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;

■ A return or increase of disability due to a consequential injury (defined as one that occurs due to weakness or impairment caused by a work-related injury); or

■ Withdrawal of a specific [limited] duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

In any of the above, the employee has the burden of proving that the work stoppage is causally related to the original OWCP-accepted injury or occupational disease.

Notice of the recurrence is made on OWCP's Form CA-2a, Notice of Recurrence, and *must* be supported by medical evidence from the employee's attending physician.¹

To be of value, this medical evidence must contain *all* of the following items:

1. An opening paragraph in which the physician describes the history provided by the employee since the employee returned to work following the injury. This should include the employee's description of his or her medical condition since returning to work, whether he or she was handicapped or in any way limited in performing his or her duties, and the employee's description of the onset of the current symptoms and disability.

2. Definitive current diagnosis (*no impressions*).

3. Opinion in definitive terms (*no speculation*): Is the current diagnosis caused by the original injury?

4. Medical rationale for opinion (i.e., what is the physician's medical reasoning linking the current diagnosis to the

original injury?).

5. The period(s) of disability attributable to the recurrence and the extent of disability during the period(s). This should specify whether the recurring disability is total or partial, and if partial (as opposed to total disability as a letter carrier) the work limitations involved while working while partially disabled.

Claims based on recurrences often fail because a physician's medical report does not contain all of the above items—the first

“ The employee has the burden of proving that the work stoppage is causally related to the original OWCP-accepted injury or occupational disease. ”

one necessary in order to prove to OWCP that the physician has been provided with an accurate “frame of reference” for his or her opinion.

The second and third items must be provided in positive terms—note that medical opinions containing words such as “might be related” or “could possibly be related” are speculative and of no value.

Finally, unless the fourth item (medical rationale) is provided, adjudication of the claim will be delayed until OWCP is satisfied that a full explanation of the basis of the physician's medical opinion is in the case record—or the claim will in all probability fail.²

1. Claim based on time lost from work because of the recurrence is made on OWCP Form CA-7, Claim for Compensation on Account of Traumatic Injury or Occupational Disease.

2. Additional information on medical rationale is provided in the May and June 1996 issues of *The Postal Record*.

Contact branch officers first

As requested previously, members are asked to refrain from contacting the NALC's Compensation Department. This is necessary because the department cannot respond on a daily basis to 312,215 members—or even the officers of NALC's 2,884 branches—and still work on major union projects for the benefit of the entire membership.

All questions and problems should be brought to the attention of branch officers, who in turn can bring questions and problems to their national business agents. Only the NBAs should contact the NALC's Compensation Department—except in the case of an emergency.

President Vincent R. Sombrotto

Fitness-for-duty examinations in FECA cases



Bert Doyle

Note: This article updates an article on the same subject in the July 1992 issue of *The Postal Record*. The previous article should no longer be used as a reference.

There is no provision for “fitness-for-duty examinations” in the Federal Employees’ Compensation Act or in the regulations of the Office of Workers’ Compensation Programs. The FECA does, however, provide OWCP with the authority to require medical examinations, sometimes referred to as medical evaluations, whenever OWCP believes it necessary.

Irrespective of the above, there are *fitness-for-duty examinations* following on-the-job injuries and illnesses. However, they are not authorized by OWCP; they are authorized by the *employing agency* as provided in regulations of the Office of Personnel Management.¹

The Postal Service’s authority to require fitness-for-duty examinations in FECA cases is reflected in Subchapter 540, Injury Compensation, of the *Employee and Labor Relations Manual (ELM)*—and specifically in 547.3, which provides that an installation head can at any time require any *employee* being treated by a physician or hospital for an on-the-job injury or illness to report to a Postal Service medical unit (or contract

equivalent) for a fitness-for-duty examination. Note that the Postal Service has no authority to require a *former employee* to undergo a fitness-for-duty examination.

Because employing agency fitness-for-duty examinations are outside OWCP’s authority, an employee’s refusal to undergo or otherwise not cooperate with such an examination is not a bar to continuation-of-pay (COP) or compensation benefits. Refusal to undergo or cooperate in a Postal Service-authorized fitness-for-duty examination may, however, result in disciplinary action.

Also, and while OWCP does not authorize or request an employing agency to conduct a fitness-for-duty examination, OWCP must consider the results of any such examination submitted by the employing agency—as it would any evidence submitted by the employing agency.

Members who believe that the Postal Service has abused its fitness-for-duty examination authority should contact an NALC branch officer or their national business agent.

Please also keep in mind that the Postal Service procedures described in *ELM* 547.3 apply only to FECA cases—different procedures apply to other situations involving Postal-Service-authorized fitness-for-duty examinations (e.g., general employability and disability retirement). ☒

¹ 5 CFR 339.301 (c).

Use of functional capacity evaluations in fitness-for-duty examinations

Functional capacity evaluations, sometimes called “isokinetic testing” or “physical capacity testing” are being utilized by some Postal Service installations as part of fitness-for-duty examinations. While the local instructions vary to some extent, the purpose is clear: an evaluation of an employee’s physical strength capabilities and pain level—particularly in regard to the back, shoulders, elbows, or knees. An FCE may involve the use of equipment that is somewhat similar in appearance to body-building equipment at physical fitness facilities.

The employee should immediately contact his or her attending physician to determine if the FCE could possibly be injurious. If so, a medical report from the attending physician should be presented to the Postal Service installation (and

a copy sent to OWCP for informational purposes).

Refusal to undergo a Postal Service-requested FCE is not a bar to receipt of continuation-of-pay (COP) or compensation benefits and employees faced with Postal Service demands that they undergo an FCE should also contact an NALC branch officer or their national business agent for advice and assistance on a case-by-case basis—whether or not the employee is threatened with disciplinary action.

In no situation should an employee sign a consent form in which the employee provides written evidence that he or she agrees to an FCE. A consent form may release the evaluating facility and/or equipment manufacturer from liability should the FCE result in injury to the employee. ☒