Understanding the Adjudication Process

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What is “adjudication”?

- *Adjudication* is the process of developing the evidence in a claim for workers’ compensation and making a decision on the issues in that claim.
Short Form Closure Cases

- Not all claims are adjudicated
- Traumatic injury claims which are uncontroverted and meet the criteria to be classified as simple injuries which do not require surgery or wage loss compensation (following the COP period) are administratively handled as “short form closures”
Short Form Closure Cases

- Criteria for short form closure cases is listed in the FECA Procedure Manual (section 1-0400-4)
- Certain types of injuries are excluded. Examples: Emotional or heart condition claimed; vehicle accidents; violence; animal attacks; communicable diseases; claims from certain agencies
Short Form Closure Cases

- Short form closure cases are opened for payment of medical bills up to $1500 and COP by the agency, but are not reviewed by a Claims Examiner.

- Later developments in the case may require the claim to be adjudicated, such as a surgery request, medical bills in excess of $1500, receipt of a claim for compensation (CA-7 form) or claim for recurrence (CA-2a form).
Short Form Closure Cases

- If a short form closure case is reopened due to one of these triggers, the Claims Examiner will review the evidence in file and proceed to adjudicate the case. Any necessary development of evidence will occur at that time.
Adjudication

- Any traumatic injury claim which does not meet the criteria for creation as a short form closure, and any claim for occupational disease (form CA-2) or death benefits, is adjudicated by a claims examiner.
On first review, the CE will determine whether there is sufficient evidence to adjudicate the case. If not, a letter is sent to the claimant.

If medical evidence is missing, the CE will request it. If factual evidence is missing, or there are disputed facts, further information will be requested.
Development

- It is the claimant’s burden to provide all necessary evidence, except that in possession of the agency. The agency must provide any relevant information it has.

20 CFR 10.115(f); 10.118(a)
Development

- The CE will allow at least 30 days for response from the claimant.
  
  20 CFR 10.121

- Failure to allow at least 30 days before making an adverse decision is reversible error.

- The CE must explain deficiencies in initial evidence – which of the five basics are not established
Development

- All evidence must be submitted in writing
- At CE discretion, some types of factual evidence may be developed by formal telephone conference. If conducted, written conference memo is provided to participants with time allowed for comment.
Medical reports must be signed by a physician.

Reports signed by nurse practitioners, physician assistants, etc. are not acceptable, unless countersigned by a physician.

Reports from chiropractors allowed only if subluxation of spine is diagnosed based on x-rays.
Development

- For some types of conditions, a medical examination (second opinion) is often arranged by OWCP in order to adjudicate the claim.

- Examples:
  - Hearing loss
  - Asbestos/ pulmonary conditions
  - Cardiac conditions
  - Psychiatric conditions
Adjudication

- After allowing time for response from the claimant, or if all necessary evidence is present on initial review, the CE will make a decision on the case.
Step 1. Claim filed

Step 2. CE Review

Step 3. Evidence Sufficient?

No

Step 4. Develop

Repeat from Step 2

Yes

Accept

Pay Benefits

Deny

Appeals Process
Five Basics

Acceptance of a claim requires satisfaction of the Five Basics:

1. Timely filing
2. Civil employee
3. Fact of injury
4. Performance of duty
5. Causal relationship
Five Basics

- The Five Basics are hierarchical and considered in order. If a claim fails at an early level, later levels are not even considered.

- Example: Whether an injury occurred and whether a condition is related are irrelevant, if the claim is not timely filed.

Let’s look at the Basics in greater detail:
Timely Filing

- Timely filing—Rules:
  
  The **Act** (5 USC 8122) sets time limits for the filing of a claim. These are explained in somewhat greater detail in the **Regs**, 20 CFR 10.100-10.105 and in the **FECA PM**, in PM 2-801.
Timely filing

- For claims after 9/7/74, must be filed within 3 years of--
- Date of injury
- Date of first awareness/should have been aware
- Date of last exposure/retirement
Timely filing

- Exception: If the Agency had “actual knowledge” of the injury in the first 30 days, and that knowledge was such as to put the Agency on notice that there had been a work-related injury, the time requirement is met.

20 CFR 10.100(b)(1)

Examples: Evidence of “actual knowledge” might be an Agency dispensary’s medical report from the time of the injury, or reports of monitoring under an Agency monitoring program (hearing, asbestos, etc).
Civil employee

Civil employee—Rules

The definitions of an “employee” are in the Act at 5 USC 8101(1). Additional guidance is at PM 2-802, in various Program Memoranda, and in decisions of the Employees’ Compensation Appeals Board (the ECAB).
Civil employee

Usually, the question is easily answered, but there can be "borderline" cases, for example:

- LEOs (non-Federal law officers)
- Volunteers (VIPs, YCC, Job Corps, VA volunteers)
- Contractors
Decisions in “borderline” cases are often significantly more difficult. Issues involved (and you may need to help with these) may be statutory authority to accept the services, extent of actual control or supervision of a contractor, activity actually engaged in when injured and its relationship to the Federal government.
Fact of Injury

- Claimant’s burden to support, with evidence, the two parts to fact of injury:
  - 1) Medical evidence must establish that a condition has been diagnosed
  - 2) Factual evidence must establish that the claimed incident or exposure occurred in the time, place and manner alleged
Fact of Injury

- An employee's statement alleging that an incident occurred at a given time, place and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence.

- However, CE also considers circumstances of the claim filed, in determining if FOI is established (ex.: unexplained delay in filing claim, ambiguous or inconsistent statements)
Performance of Duty

- In order to be compensable under the Act, an injury must arise “out of, and in the course of, employment.”

- Two tests: “in the course of employment” generally means while the employee is at work. “Out of employment” means that something about the work or workplace led to the injury.

- Must meet both tests.
Performance of Duty

- **Premises**
  - fixed place of employment
- **Recreation**
  - formally organized
- **Union Duties**
  - representational activity covered
- **Horseplay**
  - if together for periods of time
- **Personal comfort doctrine**

- **To & From Work**
  - not usually covered
  - “going and coming rule”

- **Misconduct**
  - violating safety rule or laws
  - negligence not enough

- **Intoxication**
  - by drug or alcohol
  - must be the “proximate cause” of injury
Performance of Duty—some issues

- **Idiopathic Falls**
  - known, non-work-related, pathology
  - intervening object

- **Unexplained Fall**
  - Unknown etiology

- **Travel Status**
  - reasonably incidental and NOT a...

- **Diversion from Duty**

- **Assault Cases**

- **Coworker Harassment or Teasing**
Causal relationship

This is the link between the work-related injury or exposure and the medical condition being claimed. There are four types of causal relationship--

- direct cause
- aggravation
- acceleration
- precipitation
Causal Relationship

- The physician must provide a rationalized medical opinion explaining the connection between the diagnosed condition and the work related incident or exposure.
- This is especially important in occupational disease claims.
- In simple, straightforward claims, lack of a rationalized opinion on CR may be excused.
Causal relationship

- Unlike the other four of the Five Basics, causal relationship is not a one-time thing. The claimant must show that it continues throughout the life of the claim.

- Compensation continues as long as there continues to be disability for work (total or partial) that is causally related to the work injury.
Causal relationship

- In order to terminate compensation, the Office must show, with the weight of rationalized medical evidence, that causal relationship has ceased.
There are three primary sources that guide decisions, and several auxiliary sources.

Primary sources—

- The Act (the Federal Employees’ Compensation Act), 5 USC 81. Federal law. Broad and general
- The PM (FECA Procedure Manual), Pt 2—Detailed instructions
Decision

- Auxiliary sources—
  - Decisions of the Employees’ Compensation Appeals Board (ECAB). Highest appellate body under FECA
  - FECA Program Memoranda
Decision - Acceptance

- If the claim is accepted, the CE enters the accepted ICD-9 diagnosis(es), and sends a letter to the injured worker advising of acceptance and entitlement to benefits.

- Partial acceptance is possible – one or more diagnosis accepted, but other claimed conditions denied or developed further.
Decision - Denial

- If evidence is found insufficient to accept the claim, a decision is sent to the claimant discussing evidence received and explaining which element(s) of the five basics were not established.
- Appeal rights are provided with the decision
Decision - Denial

- Appeal Rights are issued with any adverse decision:
  - Oral Hearing by Branch of Hearings and Review
  - Review of written evidence by Branch of Hearings and Review
  - Reconsideration by Senior Claims Examiner in the district office
  - Review by Employees’ Compensation Appeals Board
Disputing claims

- As with controversies of COP, the CE looks for clear, convincing evidence to support any disputes you have with the claim.
- If you have documentation, send it in.
- If you have witness statements, send them in.
Disputing claims

- Build a good reputation with your local Office(s). If you dispute every claim and never provide more than vague statements or “mushy” evidence, you will lose most of the time.
- If you dispute only selectively and provide decent evidence, you will win.
The key is to remember that CEs are busy and don’t like to feel like their time has been wasted.
Continuation of Pay
Continuation of Pay

- Where the Agency controverts payment of Continuation of Pay (COP), OWCP must review the case and make a decision whether COP should be paid.

- The decision must be based on the written evidence in the case, and the Agency and claimant (and rep, if there is one) informed of the decision.
Continuation of Pay

- The CE must consider the arguments and evidence presented by both sides. The decision is made on the basis of:
  - Clear and convincing quality of the evidence and arguments,
  - Regulatory guidance at 20 CFR 10.220
Continuation of Pay

- Upon receipt of a controverted CA-1, the CE will review the evidence and controversion reason provided. If additional information is needed to make a decision, the agency will be instructed to pay COP pending adjudication of the claim.

- If COP entitlement is clearly not established, the agency will be instructed not to pay COP, but a formal denial of COP will not be issued until the claim itself has been adjudicated.
COP – Controversion Reasons

1. Disability not caused by traumatic injury
2. Not a citizen of US or Canada
3. No written claim within 30 days
4. Injury not reported prior to termination of employment
5. Injury occurred off premises and not in POD
COP – Controversion Reasons

6. Injury caused by willful misconduct, intent to injure or kill self or other(s), or due to intoxication by illegal drugs or alcohol

7. Work did not stop until more than 45 days after injury

8. Employee is a member of excluded group (Peace Corps, Job Corps, YCC, person serving without pay, staff of former president, etc.)

20 CFR 10.220
Evidence needed to prove each varies, depending on what you have to prove.

It is relatively straightforward to prove citizenship, claim filing, termination of employment or work stoppage.

- Documentary evidence
COP

- That an injury is an occupational disease, not a traumatic injury, usually will rest on the medical evidence.

- Proving that an injury was off-premises and not work-connected may be easy or difficult—submit whatever documents, witness statements, or the like you have or can obtain.
Proving willful misconduct, intent to injure or kill, or intoxication is usually extremely difficult.

- “Intent” or “willfulness” is inherently difficult to prove
- Carelessness ≠ “willfulness”
- Intoxication: Provide all evidence you can—witness statements, police reports, tox screen results, etc.
Willful misconduct, intent to injure, and intoxication are considered total "bars" to compensation. The issues must be raised as soon as you are aware they may apply, as they are supposed to be raised by the Office at the time of initial adjudication.
Medical Authorization Requests – CE Role

- Medical authorization requests and bills are submitted to, and processed by ACS.
- The medical provider must specify procedure codes, dates of service, units, diagnosis being treated, etc.
- Decisions on authorization of the request are guided by “treatment suites”
Medical Authorization Requests – CE Role

- The treatment suite defines which medical procedures are allowable for the diagnosis(es) that have been accepted by OWCP as work related.
Medical Authorization Requests – CE Role

- Medical authorization requests are classified according to four levels:
- Level 1: No authorization required (ex.: office visits, routine diagnostic tests)
- Level 2: Authorization required (ex.: therapeutic procedures, basic medical equipment) Request is reviewed, and may be authorized, by ACS staff depending on case status. Review by CE may be needed
Medical Authorization Requests – CE Role

- Level 3 and Level 4: Authorization required (ex.: invasive diagnostic procedures, surgeries, costly medical equipment) ACS will contact the CE, who will review medical documentation and advise ACS of status of the request
Medical Authorization Requests – CE Role

- If the request cannot be authorized by ACS, a computer message ("thread") is sent to the CE requesting instruction how to proceed.
- The CE reviews the request and evidence in file, and advises ACS whether it is approved, denied, or requires medical development.
Medical Authorization Requests – CE Role

- If medical development is required, the CE must take action to develop the request.
- Development may involve correspondence with the treating physician, review by the DMA or referral for a second opinion.
- Upon completion of the development, ACS is advised of the decision on the request.
- If a request is denied, a formal decision may be issued, with appeal rights.
Medical Authorization Requests – CE Role

- If a request cannot be authorized due to a treatment suite mismatch:
  - CE reviews medical evidence to determine if another diagnosis may be accepted.
  - If so, ACS is advised, and the requested procedure is checked against the treatment suite for the new accepted diagnosis.
  - If no additional diagnoses may be accepted based on current evidence, development is required.
If a physician disagrees with denial of a requested procedure based on the treatment suite, he/she may submit an explanation of the need for the requested procedure to treat the accepted diagnosis, for review by OWCP.
Questions?