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FEDERAL WORKERS' COMPENSATION FRAUD AND ABUSE

HEARINGS

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

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CONTENTS

EXHIBITS

APPENDIX

FEDERAL WORKERS' COMPENSATION FRAUD AND ABUSE

WEDNESDAY, JULY 22, 1981

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, D.C.

The subcommittee met at 9:35 a.m., pursuant to notice, in room 3302, Dirksen Senate Office Building, under authority of Senate Resolution 361, dated March 5, 1980, Hon. William V. Roth, Jr. (chairman of the subcommittee) presiding.

Members of the subcommittee present: Senator William V. Roth, Jr., Republican, Delaware; Senator William S. Cohen, Republican, Maine; Senator Warren B. Rudman, Republican, New Hampshire; and Senator Sam Nunn, Democrat, Georgia.

Members of the professional staff present: S. Cass Weiland, chief counsel; Michael Eberhardt, deputy chief counsel; Katherine Bidden, chief clerk; Marty Steinberg, chief counsel, minority; Howard Cox and Howard Shapiro, staff counsels; and Karen Hainer, investigator.

Chairman ROTH. The subcommittee will come to order.

OPENING STATEMENT OF SENATOR ROTH

Chairman ROTH. This morning the Senate Permanent Subcommittee on Investigations will commence a 2-day hearing into fraud and abuse in the operation of the Federal Employees' Compensation Act.

Federal workers' compensation benefits are among the most generous benefits offered to injured workers in the United States. Unfortunately, the Federal Government's generosity is subject to abuse by unscrupulous individuals who seek to unlawfully benefit by exploiting the weaknesses in the program.

These hearings are designed to identify those types of abuses which are prevalent in the workers' compensation system and to assess the management of that system by the Department of Labor.

It should be noted at the outset that this hearing is not designed to condemn the Federal workers' compensation program. Federal employees who are injured on the job are absolutely entitled to be compensated for their injuries and should receive reasonable medical treatment for those injuries. However, as with every program which involves the expenditure of public funds, the Government must know whether these funds are being properly expended. For this reason, the subcommittee has undertaken this examination of the program. The question is, Are Government funds unnecessarily spent on fraudulent claims or lost through wasteful management practices of the Department of Labor or other agencies?

I think it is important to point out that since 1974, expenditures to Federal employees on compensation benefits have increased over 300 percent. In fiscal year 1980 alone, the Government expended over $670 million in disability benefits and $110 million in medical benefits related to disability. This amazing increase in the amount of money expended has occurred during a time when safety efforts in Federal workplaces have increased and the size of the civilian Federal work force has remained relatively constant.

The focus of these hearings today will be to identify fraudulent practices by medical service providers and by Federal employees in filing claims for nonexistent injuries and for medical treatments that were never provided.

The hearing will also identify repeated failures by the Department of Labor to adequately examine claims filed in order to detect wasteful and abusive practices and to eliminate from the rolls those claimants whose injuries are not disabling, and who are not entitled to further compensation.

Additional emphasis will be given to the means by which the Government can protect itself from medical service providers who have prior histories reflecting fraud and abuse in delivery of services to Government entities.

The hearings will commence with a summary of the investigative work performed by the subcommittee staff in identifying the schemes used by medical service providers to defraud the Government. Later, testimony will be received from other law enforcement officials who will recount their efforts to combat crime in the program.

These witnesses will show that the program is an easy target for individuals who wish to abuse the liberal benefits provided by the Federal Government.

We shall also receive testimony from the GAO, concerning their reviews of the program and from the Department of Labor concerning their management of the program. We hope to acquire from these witnesses the appropriate insight into the means, legislative and otherwise, which can be developed to effectively deal with abuse in the Federal workers' compensation program.

Let me say in opening these hearings that one of the things that has concerned me the most in these investigations, first, in the home health care program and now here, is the lack of what I see as adequate internal controls.

I want to underscore to the people in the various agencies that this is not just going to be a 2- or 3-day media event. We are going to be interested in finding out what the agencies and the Department of Labor does to correct the deficiencies of the program. We expect to hold, 6 months from now, or a year, further hearings to see what remedies have been taken.

I can assure the executive branch that we are also going to talk to OMB about who is responsible for management, and to call upon them to follow through to see that corrective action is taken.

At this time, I would like to call upon my distinguished colleagues for any comments they may care to make.

Senator Cohen.

OPENING STATEMENT OF SENATOR COHEN

Senator COHEN. Mr. Chairman, I have a prepared statement[1] I would like to have entered in the record, but first I commend you for continuing the pledge you made at the beginning of the 97th Congress to root out fraud, waste, and abuse in all our Federal programs. It seems to me we have discovered a consistent pattern of abuse in the hearings we have had to date; that is, we seem to have no effective means, as you suggested, of prevention of abuse with respect to home health care. But, I would go further and say we either have no effective means or no serious intents of suspending fraudulent conduct or inept conduct by those who contract with the Federal Government. In the case of home health care, we found that one firm that either defrauds the Government or does not perform services can simply go out of business as such, form another company with a different name but with the same management, and continue to do business with the Federal Government, either providing no services or highly inflated services which are borne by the taxpayers.

We went on further in Government Oversight Committee hearings to see contractors who are, in fact, debarred by one agency for either fraud or incompetence, being able to walk right across the street and secure and arrange another contract with a different Federal agency because there is no governmentwide binding resolution, as such, on the other agencies when one firm has been debarred by an agency.

Now we come to this particular field, the Federal workers' compensation program, and we have a situation where a physician has to lose his license in order to be debarred from receiving business through reimbursement from the Federal Government.

If the physician defrauds the Government and is convicted of fraud, still the Department of Labor will continue to pay him or reimburse him for services until such time as his license to practice is revoked.

First, I would point out that a fraud conviction rarely results in revocation of a physician's license. But more importantly, in my judgment, it is unconscionable for us to delegate to the AMA the responsibility to the American taxpayers to control abuse. This cuts across more than just this simple issue, but rather it is a widespread problem we have in the Federal Government, either having no effective means or no serious intents to control abuse.

Chairman ROTH. I think it goes back to a lack of internal controls that seems to be rather prevalent in some of these programs, and I will be very candid, I think this is one reason for the taxpayer or the public's lack of confidence in Government.

Unfortunately, the people who suffer the most are the Federal employees because they are criticized for the cost of these programs. So I think we must do something about it.

Senator Nunn?

OPENING STATEMENT OF SENATOR NUNN

Senator NUNN. Thank you very much, Mr. Chairman.

I congratulate you and the majority staff in your efforts in direct-

[1] See p. 115 for the prepared statement of Senator Cohen.

ing our attention and the attention of the Congress and the public to this area of fraudulent abuse.

The Federal Employees' Compensation Act was designed to insure the full compensation of Government employees for work-related injuries. The facts that have been put before this subcommittee and which will be put in the next several days depict a result which was certainly unintended. It is my understanding that there are allegations that the payment of substantial amounts of Federal funds for overstated and often nonexistent medical services is commonplace, and that the evidence and testimony produced during the course of the hearing will underscore the critical need for stricter controls, as you already mentioned and Senator Cohen mentioned, and monitoring by the Department of Labor in the payment of compensation claims under the act.

Mr. Chairman, as you know, we had hearings before this subcommittee on waterfront corruption this year and during the course of those hearings, we got into the workmen's compensation area and the great abuses taking place on the waterfront. Of course, Senator Rudman, myself and others have sponsored a bill which is now pending that would go a long way toward correcting some of the abuse we found there. Hopefully we can pass it this year. Senator Nickles is working on it.

I am interested, as these hearings unfold, as to whether we are seeing the same kinds of abuse in the Federal Employees' Compensation Act that we have seen on the waterfront. I believe these abuses can be corrected. I think they are going to take the careful attention of both the Congress and particularly those who manage the program. But I do not think there is any unsolvable problem here in trying to continue to provide adequate workmen's compensation and fair workmen's compensation to Government employees and at the same time providing protection for the taxpayers against fraud and abuse. The two have to be made compatible. We do not want to dilute the right of Federal workers, but we cannot continue to tolerate fraud and corruption in these programs if they are going to continue to exist.

One of the most disturbing parts that I have heard in some of the briefings on this testimony, which we will hear, is the inability or unwillingness to take corrective action when people have actually been convicted of fraud, particularly doctors who may continue to send in claims; that is to me inexcusable.

I congratulate you, Mr. Chairman and the majority staff, for putting this together. Our minority staff has worked with you and will continue to work with you, both in the hearings and in framing whatever legislative response is appropriate.

Chairman ROTH. I would like to thank you, Senator Nunn, for your cooperation and that of your staff.

The thing that shocks me the most is the lack of will within many of these programs to really do much to correct it. They are always going to do it tomorrow. I think we have to stop that.

I would like to call on our vice chairman, Senator Rudman.

OPENING STATEMENT OF SENATOR RUDMAN

Senator RUDMAN. Thank you, Mr. Chairman.

I join Senator Cohen and Senator Nunn in commending you for convening these hearings. I believe that there are essentially two problems

that we are facing. Senator Cohen, I think, stated it very well. I do not believe this Government can allow others to set standards as to who we will do business with. And if the agencies persist in following these practices which in my mind, as I stated at the last hearing, border on lunacy, then I think we have to have statutory enforcement to insure this Government does business with only people it ought to do business with.

I don't think we have to wait for people's licenses to be suspended before we stop doing business with them if they are convicted by a jury of their peers for fraud. I agree with that.

Second, insurance fraud in this country at all levels is a major drain on the economy. There have been investigations in probably all of the Eastern States that I am familiar with that have been run by the attorneys general of those States, insurance fraud affecting State governments in an enormous way.

That is just a tip of the iceberg. Anyone who has read through the excellent staff work done here certainly sees that there are no safeguards whatsoever to insure massive fraud against the Federal Government. It almost seems as if the goal of the agencies in some cases is to process the paperwork as quickly as possible with little regard to what is being paid. And so I hope that these hearings, and the ones that were held several months ago, will lead to some strong recommendations, if not statutory enactment, that will, in fact, start putting some systems management into place in paying these literally billions of dollars of claims. I am looking forward to these hearings continuing and being renewed again when necessary, Mr. Chairman.

Chairman ROTH. Thank you, Senator Rudman.

At this time, I would like to call upon Karen Hainer, the staff investigator, and Howard Cox, the staff counsel, to give the subcommittee the results of their work in this area.

TESTIMONY OF HOWARD W. COX, STAFF COUNSEL, AND KAREN A. HAINER, STAFF INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. Cox. Thank you, Mr. Chairman.

I would like, with your permission, sir, at this time to insert a prepared statement into the record and then briefly summarize that prepared statement for your benefit this morning.[1]

Chairman ROTH. Without objection.

Mr. Cox. I think before we get into the substantive parts of our investigation, it would be appropriate to provide a brief overview as to how the Federal Employees' Compensation Act, or FECA, is supposed to operate.

Chairman ROTH. If you would, I overlooked the fact that we have to swear all witnesses in under the subcommittee rules.

Do you solemnly swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Mr. Cox. I do.

Ms. HAINER. I do.

Chairman ROTH. Please be seated.

Mr. Cox. Sir, under the FECA Act, which has been in existence in one form or another since 1916, Federal workers injured on the

[1] See p. 116 for the prepared statement of Howard W. Cox and Karen A. Hainer.

job have an absolute right to be compensated for their injuries without regard to whose fault the injury was.

Basically, what happens is, once an employee is injured on the job, he is to report this injury to his immediate supervisor. That supervisor assists the employee in filling out the necessary form, which is forwarded to the Department of Labor, who manages the program for the Federal Government. The benefits which accrue to the injured employee are many.

First of all, the employee will receive 45 days of uninterrupted pay from the employee's agency upon notice of an injury.

At the expiration of that 45-day period, the Department of Labor assumes responsibility for paying the employee for injury benefits. Those compensation benefits paid directly to the employee could be 66⅔ of his salary tax free if he has no dependents, or 75 percent of his salary tax free if the individual has dependents. Then he is paid by the Department of Labor every 28 days, once the case has been adjudicated by the Department of Labor and accepted by them as a valid injury.

In addition, under the statute, an injured employee has a right to receive reasonable medical benefits. The doctors, physicians, hospitals, all the specialists that treat the individual, directly bill the Department of Labor for those services.

The Department of Labor, by statute, is to pay for reasonable services provided.

Then the Department of Labor receives the claim forms from the employee's agency, they assign a claims examiner to examine the claim, and determine, in accordance with the statutory restrictions, whether or not the injury meets the definition of being a work-related injury. The claims examiner examines medical documentation to determine whether or not the injury is indeed work-related.

Assisting the claims examiner is a Department of Labor District Medical Director, who is supposed to be a specialist in the concept of workmen's compensation injuries. When the claim is examined, he makes his final determination.

The expenditure of public funds would be authorized for the expenses accrued.

We should point out that in 1973, compensation benefits apart from medical benefits amounted to $186 million a year, medical benefits were $31 million a year. Seven years later in fiscal year 1980 there was a 300 percent rise in both of these benefits—compensation benefits were up to $674 million, medical benefits were up to $110 million.

I would like, with your permission, to have introduced into the record as exhibit No. 1 a chart that we have prepared breaking down the amount of money paid out in compensation benefits, the amount paid out in medical benefits, the number of claims submitted to the Department of Labor and the size of the Federal work force for each of those years. You can see from this chart that the size of the Federal work force has remained relatively constant, the number of claims has remained relatively constant, but the costs have risen 300 percent.

[The document referred to was marked "Exhibit No. 1," for reference and follows:]

EXHIBIT No. 1

Rise in FECA costs

Fiscal year 1973:	
1. Compensation payments	$186,038,000
2. Medical payments	$31,732,000
3. Claims submitted to the Department of Labor	28,344
4. Federal civilian work force	2,765,644
Fiscal year 1974:	
1. Compensation payments	$236,089,000
2. Medical payments	$34,587,000
3. Claims submitted to the Department of Labor	31,025
4. Federal civilian work force	2,893,119
Fiscal year 1975:	
1. Compensation payments	$319,460,000
2. Medical payments	$40,084,000
3. Claims submitted to the Department of Labor	35,615
4. Federal civilian work force	2,893,119
Fiscal year 1976:	
1. Compensation payments	$414,269,000
2. Medical payments	$63,118,000
3. Claims submitted to the Department of Labor	40,324
4. Federal civilian work force	2,857,472
Fiscal year 1977:	
1. Compensation payments	$482,613,000
2. Medical payments	$69,471,000
3. Claims submitted to the Department of Labor	30,301
4. Federal civilian work force	2,841,152
Fiscal year 1978:	
1. Compensation payments	$540,226,000
2. Medical payments	$86,208,000
3. Claims submitted to the Department of Labor	31,637
4. Federal civilian work force	2,872,851
Fiscal year 1979:	
1. Compensation payments	$601,410,000
2. Medical payments	$98,618,000
3. Claims submitted to the Department of Labor	30,845
4. Federal civilian work force	2,875,872
Fiscal year 1980:	
1. Compensation payments	$674,824,000
2. Medical payments	$109,957,000
3. Claims submitted to the Department of Labor	29,693
4. Federal civilian work force	3,121,769

Source: Department of Labor; Congressional Research Service.

Mr. Cox. The chart at my right also reflects those same statistics.

Given this as background, some months ago the subcommittee staff decided to examine the workers' compensation program. We decided to pick one narrow area which had not received a great deal of investigative or audit attention in the past. This was the medical benefits area. We had examined work prepared by the General Accounting Office as to the management controls and the claims processing work done by the Department of Labor.

However, their reports did not address medical claims, the concept of medical fraud and the concept of abuse by medical service providers.

As far back as 1976 the House Government Operations Committee issued a report to the Department of Labor in which they warned that the FECA program was highly susceptible to fraud by medical service providers. That report identified that medicare and medicaid

fraud was most prevalent and the kinds of fraud that were identified in those programs were easily transferable to the Department of Labor's FECA program.

Given this as background we felt this would be a fertile area for our examination.

We commenced with a brief examination of law enforcement agencies in order to determine what efforts were currently underway to investigate medical fraud in the FECA program. We contacted the Federal Bureau of Investigation, the Postal Inspection Service, and the Inspectors General of various executive agencies. We also contacted organizations that exist in the private sector. We contacted and received a great deal of assistance from the Insurance Crime Prevention Institute, which is a private organization, funded by private insurance companies, to help law enforcement organizations investigate private insurance frauds.

We also had substantial contact with the Department of Labor officials. We gained an understanding of the operation of the program. We met with central office officials here in Washington, district office officials of two district offices here in Washington as well as the Department of Labor district offices in Boston and New York City.

Based upon this examination, we concluded that a certain pattern could be developed with regard to an approach to our investigation. We found out that if a medical service provider was engaged in perpetrating a fraud scheme in medicare, medicaid, State insurance programs, or State workers' compensation programs, that those kinds of fraud patterns were easily transferable into the operation of FECA.

We also found out that whenever law enforcement agencies were actively investigating a FECA fraud, that investigation was only commenced as an afterthought to another kind of fraud, be it medicaid, State insurance, or State workers' compensation fraud.

There was very little attention directed toward investigating FECA fraud as an entity. With this in mind we received assistance from the Postal Inspection Service in identifying doctors who had been engaged in mail fraud related to insurance fraud schemes.

According to law enforcement agencies we spoke with, the mail fraud statute provided the most potent weapon to combat the fraud programs and to address the fraud potential of various Federal and State and local compensation programs. The Postal Inspection Service was able to identify for us one particular case here in D.C. which seemed to point out some of the gross weaknesses in the Department of Labor's management. That was the case of Dr. Thomas Dent.

Dr. Dent was the subject of a Postal Service investigation which indicated that Dr. Dent was engaged in private-insurance-related mail fraud. Additionally, it was pointed out by a local television station here in the Washington area that Dr. Dent was engaged in selling sick slips to Federal employees who were not sick.

Dr. Dent would have a system whereby the employee would pay a certain amount of money and receive sick slips for a certain amount of

time off. That investigation led to further inquiries as to the possibility of the falsification or provision of inflated medical reports in the FECA area. This investigation led to Dr. Dent's conviction in the U.S. District Court for the District of Columbia in June of 1981.

He plead guilty to one count of private insurance related mail fraud and one count of FECA fraud. He received a suspended sentence, probation, a $9,000 fine and was ordered to perform 250 hours of community service.

Although the court had the power at the time of sentencing to revoke Dr. Dent's license, no action was taken by the sentencing court and no such action was recommended by the U.S. Attorney's Office. We contacted the District of Columbia's medical licensing authorities who indicated to us they were not aware of Dr. Dent's conviction and they have not taken any action at this point to revoke Dr. Dent's license.

We were then informed by the Postal Service of a second example in New York City involving Dr. Richard Kones. Dr. Kones was a cardiac specialist practicing in New York.

Chairman ROTH. Let me just interrupt one moment. You are going to Dr. Kones now?

Mr. Cox. That is correct.

Chairman ROTH. Please proceed.

Mr. Cox. Dr. Kones was twice convicted in New York and Connecticut for medically related fraud schemes. He was convicted in 1974 on three counts of medicare fraud and in December 1980 for medicaid fraud in the State of Connecticut.

In neither instance was his license revoked by medical authorities. Later he was indicted in Texas, in the State of New York, and in the U.S. District Court for the Southern District of New York and is currently under these three indictments for various fraud schemes.

The Federal indictment in New York alleges fraudulent claims by Dr. Kones against social security disability, medicare, FECA, and the Federal employees health benefits program. These four Federal programs involve over $2 million of alleged fraud by Dr. Kones. The FECA counts, which account for approximately 20 counts of the 90-some count indictment, allege that Dr. Kones billed for $123,000 worth of medical payments which were never provided for an injured Federal postal worker.

I would like at this time to introduce into evidence as exhibit No. 2 a breakdown of our examination of the bills submitted by Dr. Kones on one Federal employee, amounting to $123,000 worth of services which allegedly had never been provided.

This chart located here is also a breakdown of those charges.

Chairman ROTH. Yes; I would call to the attention of everyone that the chart to my left spells out in detail the claims made in connection with this one Federal worker.

[The document referred to was marked "Exhibit No. 2," for reference and follows:]

EXHIBIT No. 2

CASES TREATED BY DR. RICHARD J. KONES

[Patient name: Peter Beccaria. Time lost from work: 14 days for 1975 injury, 20 days for 1978 injury]

	Pulled cartilage rib cage, injured Apr. 4, 1975	Injured rib cage and neck, injured Aug. 7, 1978	Total paid
Year paid:			
1975	$866		$866
1978	8,348		8,348
1979	23,153	$27,390	50,543
1980	21,714	41,712	63,426
Total	54,081	69,102	123,183

Note: Kones was indicted in New York on May 11, 1981, for 96 counts of fraud, 27 of which were FECA fraud.

Mr. Cox. We point out that no revocation of Dr. Kones' license has ever taken place by any of the State medical authorities. Based upon these two examples we confirmed the fact that the pattern that we had suspected was a valid one; that a medical service provider, engaged in one kind of fraud, could be engaged in FECA fraud. We therefore asked the Postal Inspection Service to identify a group of doctors who had been convicted of non-FECA fraud, but had been convicted of insurance-related fraud or Federal fraud of one program or another. From that point we would then find out whether or not the doctor was also participating in the FECA program and analyze that doctor's billings to determine whether or not the possibility of fraud in those billings also existed.

One such case was identified to us, the case of Dr. Allen Josephs, an osteopath located in East Northport, N.Y. Dr. Josephs was convicted in April 1981 of defrauding Blue Cross/Blue Shield in New York.

Dr. Josephs would treat an individual, who had Blue Cross coverage for a simple illness. In the course of that treatment he would obtain the names of the family members of that particular patient. He would have the patient execute a series of Blue Cross claims forms, in blank, and then would submit those claims forms, listing injuries of other family members, on a regular basis so that literally hundreds of broken arms, broken legs, cuts, lacerations, smashed toes, were billed to Blue Cross without any of those injuries ever being suffered by the family members of the particular claimant.

Blue Cross eventually detected a billing impropriety and their first impression was, given the number and kinds of injuries sustained, that Dr. Josephs was specializing in treating child abuse cases, because some of the cases involved broken arms, legs, and toes of small children and these injuries were occurring on a regular basis.

It was only when they contacted the Postal Inspection Service and began to interview these claimants that they found out the injuries never existed and treatments were never rendered.

Dr. Josephs, as I stated, conducted the scheme during the period of time 1974 to 1977. In April of 1981, he was convicted and sentenced to 1 year and 1 day in jail in the Federal Allenwood Correctional Institution in Allenwood, Pa., where he currently resides. Additionally, as

far back as 1977, New York State medicaid authorities identified Dr. Josephs as a medicaid abuser in that State. He was indicted for medicaid abuse at that time, again for overcharging for treatments that were never rendered. At the time of his indictment, Dr. Josephs entered into a voluntary agreement with the State of New York to be permanently barred from ever practicing medicaid in the State of New York again.

He was later acquitted of the medicaid fraud charges but his debarment in the State continues as a result of his voluntary agreement. As Ms. Hainer will indicate in her portion of our testimony, the Department of Labor was informed of the New York medicaid investigation of Dr. Josephs and of the possibility of double billing between FECA and New York medicaid. As Ms. Hainer will point out, nothing was done by the Department of Labor.

Given this background information, we felt that Dr. Josephs would be an appropriate case for our scrutiny. We traveled to New York and we asked the Department of Labor to identify all claims files submitted by Dr. Josephs and all patients that he had treated. They identified 20 cases for us. We analyzed all the 20 claims files that Dr. Josephs was involved with. The results of our analysis is set forth in this exhibit which I would like at this time to have introduced into the record titled "Exhibit No. 3."

Chairman ROTH. Without objection.

[The document referred to was marked "Exhibit No. 3," for reference and follows:]

84-776 O - 81 - 2

EXHIBIT No. 3

SELECTED FECA CASES TREATED BY DR. ALLEN JOSEPHS

Case no. and employing agency	Date of injury	Time off	Type of injury and treatment	Period of treatment	Number of visits	Total medical costs		
						Josephs	Tick Tock	Other
1. U.S. Postal Service	Jan. 3, 1978	74 days	Back strain and concussion; manipulation, heat and injection of muscle relaxant.	Jan. 16, 1978 to July 26, 1978	34	$739.10		$908.81
Reinjured	Oct. 24, 1980		do	Oct. 27, 1980 to Mar. 13, 1981	12	236.76		50.00
2. Veterans' Administration	Apr. 2, 1980		Back strain; manipulation and heat injection of muscle relaxant.	Apr. 28, 1980 to July 21, 1980	25	412.25	$67.50	99.00
3. U.S. Postal Service	Aug. 9, 1979	45 days	Wrist strain; examination, carpal wrist and hand injection of healing agents and anti-inflammatory agents.	Aug. 10, 1979 to Apr. 6, 1981	109	2,106.44	129.57	15.00
4. U.S. Postal Service	Sept. 13, 1977		Sprain of finger; examination, splinted finger, anti-inflammatory injection.	Sept. 16, 1977 to Aug. 27, 1980	70	1,278.14		
5. U.S. Postal Service	Mar. 1, 1980	9 days	Back strain; manipulation and heat injection of muscle relaxant—strapped back with adhesive.	Mar. 1, 1980 to July 14, 1980	40	718.80	67.50	99.00
6. U.S. Postal Service	May 5, 1980	6 days	Bursitis of knee, knee derangement; examination, strapped knee with adhesive, injection of anti-inflammatory and healing agents.	Dec. 8, 1980 to Apr. 10, 1981	25	540.55	220.10	189.44
7. U.S. Postal Service	Feb. 28, 1978	2 days	Back strain; manipulation and heat treatment, injection of muscle relaxant.	Mar. 8, 1978 to Apr. 6, 1981	269	4,491.38	700.90	
8. U.S. Postal Service	Aug. 29, 1977	69 days	do	Aug. 30, 1977 to Feb. 6, 1978	42	591.96	119.85	98.00
9. Army	Feb. 28, 1978	3 mo	Elbow strain; examination, injection of healing and anti-inflammatory agents.	Mar. 6, 1978 to Apr. 10, 1981	280	4,926.47		
10. Veterans' Administration	Mar. 30, 1979	Still off	Back strain; manipulation and heat treatment, injection of muscle relaxant.	Mar. 20, 1979 to Feb. 23, 1981	158	2,751.81		407.04
11. Veterans' Administration	Aug. 25, 1976	do	Back, hip, and leg strain; manipulation and heat treatment, injection of muscle relaxant.	Jan. 2, 1980 to Feb. 16, 1981	121	2,233.65	1,750.09	119.00
12. U.S. Postal Service	Dec. 3. 1976	80 days	Back strain and hernia; manipulation and heat treatment, injection of muscle relaxant.	Dec. 3, 1976 to Feb. 27, 1978	129	1,920.36	359.50	1,247.65
13. Veterans' Administration	Sept. 9, 1980	Still off	Back strain, hemathrosis of leg and groin; manipulation and heat treatment, injection of healing agents.	Sept. 9, 1980 to Mar. 20, 1981	46	1,023.08	539.10	448.00
14. U.S. Postal Service	Oct. 9, 1976	15 mo	Back strain; manipulation and heat treatment, injection of muscle relaxant.	Oct. 20, 1976 to Apr. 6, 1981	291	6,842.31	2,936.25	992.30
15. U.S. Postal Service	Aug. 23, 1979	5 weeks	do	Aug. 24, 1979 to Oct. 20, 1980	112	1,963.73	223.87	
16. Veterans' Administration	Jan. 22, 1974	Still off	do	Jan. 25, 1974 to Apr. 17, 1981	278+	9,108.03	2,355.24	
17. Internal Revenue Service	Dec. 14, 1978	1 mo	do	Dec. 19, 1978 to May 30, 1980	140	2,311.70	334.30	
18. U.S. Postal Service	June 10, 1976		Lacerations to knee and leg; examination, with local anesthesia, 4 deep sutures and 12 superficial to knee.	June 10, 1976 to Feb. 8, 1980	284	4,214.87	129.74	

EXHIBIT No. 3—Continued

19. U.S. Postal Service	Dec. 27, 1980	37 days	Contusions of anterior rib cage; examination, strapped rib cage with adhesive strapping, injection of muscle relaxant.	Jan. 2, 1981 to Mar. 6, 1981	19	374.87	67.50	
20. Veterans' Administration	Feb. 13, 1975	5 mo	Neck sprain, inflamation of shoulder and thoracic; manipulation, heat treatment, injection and oral muscle relaxant.	Mar. 20, 1975 to Sept. 27, 1976	162	1,950.31		1,447.48
Total					2,646	50,736.57	10,011.01	6,120.72
Grand total							66,868.30	

Source of data: Bills and payment records, Department of Labor compensation files.

Mr. Cox. As you can see from this particular exhibit, which breaks down some 20 patients treated by Dr. Josephs during the period 1975–81, we see a persistent pattern. We see repeated treatments, we see basic injuries such as strains and sprains and we see extensive periods of treatment for relatively minor injuries, particularly when you compare the length of treatment and the amount of treatment with the amount of time the employees lost from work.

For example, on this particular chart, we see here as example No. 7, a Postal Service employee who was treated during the period of time March 1978 to April 1981 for 269 visits, yet he only lost 2 days of work. We have examples where an individual lost only 3 months of work but was treated for over 3 years for over 280 visits. We see other employees who are still off from work who have had almost 300 visits of repetitive treatments which amount to nothing more than manipulation, heat treatment, and a local anesthetic injection without anybody ever getting any better.

We also detected, in the example of the bills that are provided here, that Dr. Josephs always saw all 20 patients every Monday and Friday, twice weekly without fail.

If there was a Federal holiday, he would adjust it so he would see them on Tuesday or Thursday. But it was a twice weekly visit and a consistent pattern. When we conducted our review, we only found two instances where the Department of Labor ever asked any questions and neither of those questions were ever followed up on by the Department of Labor officials.

Based on this we felt it would be appropriate to interview as many patients as we possibly could to confirm whether or not they were actually being treated in the manner in which Dr. Joseph's was billing the Department of Labor for such treatments. We eliminated seven claims files from our review. Those claims files were still under active adjudication. The Department of Labor was paying bills without determining whether or not there was actually an injury. We only picked those cases actually accepted by the Department of Labor.

Of those 13 individuals we spoke with, virtually every one, when we showed them the billing records, confirmed the existence of nonexistent treatments, nonexistent visits, nonexistent medication dispensed. All of them stated they had never been contacted by the Department of Labor to confirm whether or not they were still injured or still receiving these treatments years after the injuries.

We decided to choose three particular witnesses, who will be testifying following our testimony, who I think best typify the type of injuries Dr. Josephs handled and the way the Department of Labor managed the claims. I would like at this time to introduce into evidence as exhibits Nos. 4, 5, and 6 an in-depth examination of the particular files that were in existence in the Department of Labor breaking down the amount of money paid to Dr. Josephs for those three cases, the number of visits allegedly seen by Dr. Josephs and the types of treatment rendered in each of those cases.

The first case, sir, is exhibit No. 5. It deals with Ms. Lois Ryan. Ms. Ryan is an employee from the IRS. She injured her back at work in

December 1978, went to see Dr. Josephs for treatment. According to the billing records of the Department of Labor, Ms. Ryan visited Dr. Josephs during the period December 1978 to March 1980.

She was seen for 140 times, again on this Monday-to-Friday visitation pattern. She received a monthly prescription during the period December 1978 to August 1979 for a Darvon derivative from a local drugstore.

I would like at this time, Mr. Chairman, to introduce into evidence as exhibit 7A a copy of the initial medical report provided by Dr. Josephs on Ms. Ryan's injury.

Senator COHEN. Would you clarify from the report where you indicate she was seen 140 times that she was X-rayed, and her back was strapped with adhesive tape? She was X-rayed 140 times?

Mr. Cox. The bill that he submits doesn't indicate each time that he X-rayed her. However, the medical report submitted once a month indicates she at least received a monthly X-ray. There is an indication, as best as we can determine from the medical records obtained from the file, that at least once a month she was X-rayed.

The medical bills themselves only indicate an examination and the injection of local anesthetic. As Ms. Hainer will later point out on exhibit 7A, the cryptic nature of the information that is provided to the Department of Labor doesn't even provide Labor with enough information to adjudicate the existence of the injury or the necessity for this kind of treatment.

Exhibit 7B which I would like to also enter into evidence is an example of the medical bills submitted by Dr. Josephs, again exceedingly cryptic and quite reasonable. He only charges $11.59 per visit. I would however point out the date of this particular alleged treatment which is in the month of January 1980 and I would like at this time with your permission to have this introduced into evidence as exhibit 7B.

Chairman ROTH. Without objection.

[The documents referred to were marked "Exhibit Nos. 4, 5, 6, 7A and 7B," for reference and follows:]

EXHIBIT NO. 4

CASE TREATED BY DR. ALLEN JOSEPHS

[Patient name: Richard J. Giannino. Injury: Lacerations of knee and leg. Date of injury: June 10, 1976. Time lost from work: 7 months (approximate)]

Treatment (June 10, 1976 to Feb. 8, 1980)	Number of visits billed	Cost
Initial treatment: Examination, X-ray knee X-ray leg, with local anesthesia placed 4 deep chromic sutures and 12 superficial 3–0 silk sutures in knee, strapped knee with adhesive strapping, shots of healing agents, antitoxin, and antibiotics	1	$141.09
Subsequent treatments: Twice weekly examination: Local anesthesia, 4 deep chromic sutures and 12 superficial 3–0 silk sutures to knee. Once a week: Injection of anti-inflammatory agent	283	4,073.78
Totals	284	4,214.87

Source of data: Bills and payment record, DOL compensation files.

EXHIBIT NO. 5

CASE TREATED BY DR. ALLEN JOSEPHS

[Patient name: Lois E. Ryan. Injury: back strain. Date of injury: Dec. 14, 1978. Time lost from work: 4 weeks (approximate)

Treatment (Dec. 19, 1978 to May 30, 1980)	Number of visits billed	Cost
Initial treatment: Examination, report and manipulation, X-ray hip, strapped lower back with adhesive strapping, injection of muscle relaxant	1	$60.40
Subsequent treatments: Manipulation, heat treatment, injection of muscle relaxant	139	2,251.30
Total	140	2,311.70

Source of data: Bills and payment record, DOL compensation files.

EXHIBIT NO. 6

CASE TREATED BY DR. ALLEN JOSEPHS

[Patient name: Hector Monthalvo. Injury: Inflammation and sprained elbow. Date of injury: Feb. 28, 1978. Time lost from work: 3 mo (approximate)]

Treatment (Mar. 6, 1978 to Apr. 10, 1981)	Number of visits billed	Cost
Initial treatment: Examination and injection of anti-inflammatory agent	1	
Subsequent treatments: Examination and injection of anti-inflammatory and anesthetic agents	279	
Totals	280	$4,926.47

Source of Data: Bills and payment records, DOL compensation files.

EXHIBIT NO. 7A

A2-414266

STATE OF NEW YORK
WORKMEN'S COMPENSATION BOARD

ATTENDING PHYSICIAN'S 48-HOUR REPORT

PLEASE PRINT OR TYPE — INCLUDE ZIP CODE IN ALL ADDRESSES — CLAIMANT'S SOC. SEC. NUMBER MUST BE ENTERED BELOW

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED (City, Town or Village)	SOCIAL SECURITY NUMBER
		12-14-78	on the job	

INJURED PERSON	NAME: Lois Ryan	AGE	ADDRESS: 22 Corrane Dr., E.Npt., N.Y.	11731
EMPLOYER	IRS		Holtsville, New York	
INSURANCE CARRIER	U. S. Government		1515 Broadway, N.Y.C., N.Y.10036	

HISTORY

1. State how injury occurred and give source of this information. (If claim is for *occupational disease*, include occupational history and date of onset of related symptoms).
   While working pulling out draw injured back
2. Is there a history of unconsciousness? [ ] YES [X] NO — If "Yes," for how long? — Were X-Rays taken? [X] YES [ ] NO
3. Was patient hospitalized? [ ] YES [X] NO — If "Yes," state name and address of hospital:
4. Was patient previously under the care of another physician for this injury? [ ] YES [X] NO — If "Yes," enter his name and address, and reason for transfer under "Remarks" (Item 10).

DIAGNOSIS

5. Describe nature and extent of injury or disease and specify *all* parts of body involved:
   Lumbro-sacral strain

TREATMENT

6. Nature of treatment: Examination, Manipulation & Diathermy, Robaxin I.M., strapped low back w/adhesive strapping. X-ray Rt.Hip, A-P & lateral
   Date of your first treatment: 12-19-78 — If treatment is continuing, estimate its duration: indeterminable
   If treatment is not continuing, is this your final report? [ ] YES [X] NO — If "Yes," state date of last treatment:

DISABILITY

7. May the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent facial, head or neck disfigurement? [ ] YES [X] NO
8. Is patient working? [ ] YES [X] NO — Is patient disabled? [X] YES [ ] NO — If "Yes," estimate duration of disability: indeterminabl

CAUSAL RELATION

9. In your opinion, was the occurrence described above the competent producing cause of the injury and disability (if any) sustained? [X] YES [ ] NO

REMARKS

10. Enter here additional information of value, requests for authorization, etc.:

11. Medical testimony is occasionally required. If your testimony should be necessary in this case, please indicate the days of the week (and hours) most convenient to you for this purpose: 9-11 A.M. Tuesdays

Dated: 12-21-78 — Typed or Printed Name of Attending Physician: Dr. Allen Josephs — Address: 26 Eldorado Dr., E.Npt., N.Y. 11731

Type Rating Code	WCB Authorization No.	Telephone No.	Written Signature of Attending Physician
X-RF	210980	499-2767	

C-48 (12-73) ANSWER ALL QUESTIONS. AVOID USE OF INDEFINITE TERMS

See Reverse Side

EXHIBIT No. 7B

STATEMENT

499-2767

DR. ALLEN JOSEPHS
26 ELDORADO DRIVE
EAST NORTHPORT, N. Y. 11731

Jan. 25, 19 80

Lois Ryan
22 Zoranne Dr.
E. Npt., NY

EDS—7

30 JAN 1980

FOR PROFESSIONAL SERVICES

1-8-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
1-11-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
1-14-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
1-18-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
1-21-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
1-25-80	Manipulation & Diathermy	11.59
	Robaxin I.M.	4.90
		$ 98.94

Dr. Josephs Tax ID# 405-42-5816
WCB# A2-414266

1680
36-4300-103

APPROVED
DIRECT
REIMB
FOR $ 98.94
DATE 2-6-80
INITIAL

D.O.I.
12/14/78

KHLA50

Encl. to DAP Bulletin No.

Form CA-4-9 (T)

Mr. Cox. Based upon what we have seen in the Department of Labor's medical files we went out and interviewed Ms. Ryan. Ms. Ryan indicated she was injured in December 1978, did see Dr. Josephs in December 1978 but stopped seeing him in March 1979 and never saw him for that injury from that point ever again, thus leading us to the conclusion that Dr. Josephs' billings for March 1979 to March 1980 were untruthful. As that bill in March 1980 indicates, he was allegedly still seeing her twice a week, every week, week in and out for the entire year.

Those bills are in the Department of Labor files and were paid by the Department of Labor without question. Ms. Ryan stated she had never been contacted by any Department of Labor official to confirm the continued nature of these treatments. She also indicated that, with regard to the drugs that had allegedly been dispensed and paid for by the Department of Labor she had the prescription filled once and never had the prescription refilled. So the Department of Labor paid for a fictitious refill of her prescription.

Our second case is the case of Mr. Richard Giannino. Mr. Giannino was a postal employee and his chart is set forth in exhibit No. 4. He was injured on the job in East Northport, New York, when he cut his leg in June 1976.

According to the Department of Labor records, he was treated by Dr. Josephs from June 1976 to February 1980.

He had 284 visits, again the Monday to Friday visitation pattern without fail. Exhibit 8A, which I would like at this time, with your permission, to introduce into evidence, is a copy of the first medical report submitted on Mr. Giannino's case. It indicates that Dr. Josephs decided to give him a tetanus shot, a shot of local anesthetic, strapped his left knee with adhesive strapping and placed four chromic sutures and 12 superficial sutures in this individual's leg.

This was the first report provided to the Department of Labor. I would like also to introduce at this point as exhibit 8B a copy of the medical report submitted by Dr. Josephs on this case in February of 1980, some 4 years later. A report similar to this report was submitted by Dr. Josephs each and every month during the period of time of his alleged treatment of Mr. Giannino; and as exhibit 8B indicates, on the visit of February 8, 1980, again, Mr. Giannino received a local anesthetic, four chromic sutures and 12 superficial sutures.

Every month, month in, month out, without question, the Department of Labor paid for these treatments.

[The documents referred to were marked "Exhibits Nos. 8A and 8B," for reference and follows:]

EXHIBIT No. 8A

STATE OF NEW YORK
WORKMEN'S COMPENSATION BOARD

ATTENDING PHYSICIAN'S
48-HOUR REPORT

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED
		6-10-76	On the job

INJURED PERSON	NAME Richard Giannino	AGE 28	ADDRESS 2 Cornwall Dr.,E.Npt.,N.Y.
EMPLOYER	East Npt. Post Office		Larkfield Rd.,East Northport,N.Y.
INSURANCE CARRIER	U.S.Gov't		1515 Bway, N.Y.C.,N.Y.

1. State how injury occurred and give source of information. (If claim is for occupational disease, include occupational history and date of onset of related symptoms).
While working banged left knee & caused lacerations to left knee & le

2. Is there a history of unconsciousness?	[ ] YES [X] NO	If "Yes," for how long?	Were X-Rays taken? [X] YES [ ] NO
3. Was patient hospitalized?	[ ] YES [X] NO	If "Yes," state name and address of hospital.	
4. Was patient previously under the care of another physician for this injury?	[ ] YES [X] NO	If "Yes," enter his name and address, and reason for transfer under "Remarks" (item 10).	

5. Describe nature and extent of injury or disease and specify all parts of body involved.
Hemarthrosis left knee & deep laceration of left knee & leg

TREATMENT

Tetanus Toxoid 1cc I.M.,Terramycin 2cc I.M.,strapped lft knee with adhesive strapping.

6. Nature of treatment: Local anesthesia w/2% Zylocaine,placed 4 deep chromic sutures & 12 superficial 3-0 silk sutured in left knee

Date of your first treatment: 6-10-76	If treatment is continuing, estimate its duration. ?
If treatment is not continuing, is this your final report? [ ] YES [ ] NO	If "Yes," state date of last treatment

DISABILITY

7. May the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent facial, head or neck disfigurement? [ ] YES [X] NO

8. Is patient working?	[ ] YES [X] NO	Is patient disabled?	[X] YES [ ] NO — If "Yes," estimate duration of disability: ?

CAUSAL RELATION

9. In your opinion, was the occurrence described above the competent producing cause of the injury and disability (if any) sustained? [X] YES [ ] NO

REMARKS

10. Enter here additional information of value, requests for authorization, etc.:

10. (a) Medical testimony is occasionally required. If your testimony should be necessary in this case, please indicate the days of the week (and hours) most convenient to you for this purpose. Tuesday 9-11 A.M.

Dated	Typed or Printed Name of Attending Physician	Address
6/11/76	Dr. Allen Josephs	26 Eldorado Dr.,E.Npt.,N.Y.11731
WCB Rating Code: X-0P	WCB Authorization No.: 210980	Telephone No.: 864-2767
		Written Signature of Attending Physician: [signature]

C-48 (7-82) ANSWER ALL QUESTIONS. AVOID USE OF INDEFINITE TERMS
See Reverse Side

EXHIBIT No. 8B

ATTENDING PHYSICIAN'S PROGRESS REPORT — WORKERS' COMPENSATION BOARD
DO NOT USE THIS FORM UNLESS YOU INITIALLY FILED A FIRST REPORT (C-48)

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED (City, Town or Village)	CLAIMANT'S SOC. SEC. NO.
20350217		6-10-76	on the job	

INJURED PERSON	Richard Giannino (First Name) (Middle Initial) (Last Name)	AGE 31	ADDRESS 2 Cornwall Dr., E. Npt., NY	APT. NO.
EMPLOYER	E.Npt. Post Office		Larkfield Rd., E.Npt., NY	
INSURANCE CARRIER	U. S. Government		1515 B'way., NYC., NY	

MESSAGE TO DOCTOR THIS REPORT MUST BE FILED AT INTERVALS OF 22 DAYS OR LESS DURING CONTINUING TREATMENT. SEND ORIGINAL TO WORKERS' COMPENSATION BOARD AND COPY TO INSURANCE CARRIER. FAILURE TO FILE REPORTS ON TIME MAY RESULT IN YOUR BILL BEING INVALIDATED. PLEASE COMPLETE THIS FORM IN FULL.

1. THIS IS A (CHECK ONE): [X] PROGRESS REPORT [ ] FINAL REPORT

2. DATE(S) OF EXAMINATION ON WHICH REPORT IS BASED: 2-8-80 — WHEN WILL PATIENT BE SEEN AGAIN?

3. AT TIME OF LAST EXAMINATION (a) HAS PATIENT RETURNED TO WORK? [YES] [NO] — IF "YES" DATE RESUMED REGULAR WORK — DATE RESUMED LIMITED WORK

(b) IS PATIENT DISABLED? [YES] [NO] — If "Yes" check one: [ ] Total disability [ ] Partial disability — ESTIMATE LENGTH OF DISABILITY: Totally disabled until ____ Partially disabled until ____

NOTE: IF ABLE TO WORK PLEASE ADVISE PATIENT TO CONTACT EMPLOYER.

4. DESCRIBE SUBJECTIVE COMPLAINTS AND PHYSICAL FINDINGS WHEN EXAMINED:
Hemarthrosis and Muositis of left knee and deep laceration of left knee and leg.

5. DESCRIBE TREATMENT RENDERED SINCE LAST REPORT AND PLANNED FUTURE TREATMENT
Local anesthesia w/2% Xylocaine, placed 4 deep Chromic sutures and 12 superficial 300 silk sutures in left knee.

6. IS AUTHORIZATION FOR SPECIAL SERVICES REQUESTED? (SEE ITEM 3 ON REVERSE) [YES] [NO]

7. (a) WAS THE OCCURRENCE DESCRIBED IN YOUR INITIAL FORM C-4B THE COMPETENT PRODUCING CAUSE OF THE INJURY AND DISABILITY (IF ANY) SUSTAINED? [YES] [NO]
(b) DID YOU FILE AN INITIAL REPORT (FORM C-4B) STATING HOW THE INJURY OCCURRED? [YES] [NO] IF "NO" ATTACH FORM C-4B TO THIS REPORT.

8. MAY THE INJURY RESULT IN PERMANENT RESTRICTION, TOTAL OR PARTIAL LOSS OF FUNCTION OF A PART OR MEMBER, OR PERMANENT FACIAL, HEAD OR NECK DISFIGUREMENT? [YES] [NO] IF "YES" DESCRIBE

9. WAS PATIENT HOSPITALIZED SINCE LAST REPORT? IF SO, WHAT HOSPITAL AND WHEN? [YES] [NO]

9. (a) ANY FACTORS DELAYING RECOVERY? IF "YES" DESCRIBE [YES] [NO]
(b) IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? IF "YES" GIVE DETAILS [YES] [NO]
(c) IF "YES" HAS REFERRAL BEEN MADE? (GIVE DETAILS) [YES] [NO]

10. ENTER HERE ADDITIONAL PERTINENT INFORMATION, WORK LIMITATIONS, IF ANY, ETC.
unable to bend left knee without pain

Dated	Typed or Printed Name of Attending Physician	Address
2/11	Dr. Allen Josephs	26 Eldorado Dr., E. Npt., NY 11731
WCB Rating Code: X-0P	WCB Authorization No.: 210980	Telephone No.: 499-2767
		Written Signature of Attending Physician (Facsimile Not Accepted): [signature]

C-4 (11-78) SEE REVERSE SIDE FOR SPECIAL INSTRUCTIONS

Mr. Cox. As we can see from chart No. 4, this continued suturing or alleged suturing of Mr. Giannino cost the Department of Labor $4,200 over that period of time. The typical bill submitted by Dr. Josephs would be exhibit 8C, which I would like to have introduced into evidence at this time.

Chairman ROTH. Without objection.

[The document referred to was marked "Exhibit No. 8C," for reference and follows:]

EXHIBIT No. 8C

STATEMENT

117-350217

DR. ALLEN JOSEPHS
26 ELDORADO DRIVE
EAST NORTHPORT, N.Y. 11731

December 3, 1979

Richard Giannino
2 Cornwall Dr.
E. Northport, NY

FOR PROFESSIONAL SERVICES:

10-12-79	Examination	$9.90
	Depo-Medrol 2cc I.M.	9.77
10-20-79	Examination	9.90
10-26-79	Examination	9.90
	Depo-Medrol 2cc I.M.	9.77
11-2-79	Examination	9.90
	Depo-Medrol 2cc I.M.	9.77
11-9-79	Examination	9.90
11-16-79	Examination	9.90
	Depo-Medrol 2cc I.M.	9.77
11-23-79	Examination	9.90
11-30-79	Examination	9.90
	Depo-Medrol 2cc I.M.	9.77
		$ 128.05

Dr. Josephs Tax I.D. #495-42-5812
Carrier Case #020350217

DIRECT PAYMENT APPROVED
FOR $ 128.05
DATE 12-12-79
INITIAL C.F.

7 DEC 1979

500 1 36-4302-163

Mr. Cox. This bill indicates a Monday to Friday visit pattern during October and November 1979. We were somewhat concerned about his knee treatment, we were hoping to see that he was still on crutches from having his knee restitched so many times.

We found a rather healthy individual who indicated to us that he did indeed see Dr. Josephs. However, he had his knee stitched once; saw Dr. Josephs from the period June 1976 to approximately February 1977 and never saw Dr. Josephs for that knee injury again.

Therefore, the indication is that Dr. Josephs continued to bill for 3 years' worth of unprovided treatments, Monday to Friday without question, bills paid again without question.

Our third case deals with Mr. Hector Monthalvo, set forth in exhibit No. 6.

Mr. Monthalvo in 1976 was a Department of the Army civilian employee. He was injured in February 1978 when he sprained his elbow climbing off a piece of military equipment. Again, according to the Department of Labor, he was treated by Dr. Josephs from the time of his injury until April 1981; over 280 visits, Monday to Friday, without fail, summer, fall, winter, and spring and every second visit he received an injection of a local anesthetic.

Dr. Josephs medical report on this case will be exhibit 9A, which I would like to introduce into evidence. This would be one of the first medical reports submitted by Dr. Josephs. And exhibit 9B would be a medical bill submitted by Dr. Josephs indicating for the period of July 1979, twice-weekly treatment and once-a-week shots to Monthalvo.

Chairman ROTH. Without objection.

[The documents referred to were marked "Exhibits Nos. 9A and 9B" for reference and follows:]

EXHIBIT No. 9A

PROGRESS REPORT

PHYSICIAN | PODIATRIST | CHIROPRACTOR

CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE (City, Town)
A2395530	2-28-78	on the job

PRINT OR TYPE

INJURED PERSON	Hector (First Name) Monthalvo (Middle Initial) (Last Name)	AGE 47	ADDRESS 54 Elberta Dr., E. Nor., NY 11731
EMPLOYER	USH D/G SPT Maintenance Activity		2755 Maple Ave., Bellmore, NY
INSURANCE CARRIER	U. S. Government		1515 Broadway, NYC., NY 10036
SUPERVISING PHYSICIAN (If any)			

MESSAGE TO DOCTOR

THIS REPORT MUST BE FILED AT INTERVALS OF 22 DAYS OR LESS DURING CONTINUING TREATMENT. SEND ORIGINAL TO WORKERS' COMPENSATION BOARD AND COPY TO INSURANCE CARRIER. FAILURE TO FILE REPORTS ON TIME MAY RESULT IN YOUR BILL BEING INVALIDATED.

PLEASE COMPLETE THIS FORM IN FULL

★ IF AUTHORIZATION FOR SPECIAL SERVICES IS REQUIRED SEE ITEMS 3 AND 4 ON REVERSE

THIS IS A (CHECK ONE): [X] PROGRESS REPORT [ ] FINAL REPORT

DATE OF YOUR FIRST TREATMENT: 2-28-78

1. DATE(S) OF EXAMINATION ON WHICH REPORT IS BASED: 4-17-81 — WHEN WILL PATIENT BE SEEN AGAIN? APR. 20TH OR PRN

2. AT TIME OF LAST EXAMINATION (a) HAS PATIENT RETURNED TO WORK? [X] YES [ ] NO — IF "YES": DATE RESUMED REGULAR WORK — DATE RESUMED LIMITED WORK

(b) IS PATIENT DISABLED? [X] YES [ ] NO — If "Yes" check one: [ ] Total disability [X] Partial disability — ESTIMATE LENGTH OF DISABILITY: Totally disabled until — Partially disabled until

NOTE: IF ABLE TO WORK PLEASE ADVISE PATIENT TO CONTACT EMPLOYER.

3. DESCRIBE NATURE AND EXTENT OF KNOWN OR REPORTED INJURY OR DISEASE WHEN EXAMINED, AND ANY CHANGE OF CONDITION SINCE LAST REPORT.

Hemarthrosis and Myositis of left elbow

4. DESCRIBE TREATMENT RENDERED SINCE LAST REPORT AND PLANNED FUTURE TREATMENT

Examination, strapped left elbow with adhesive strapping and Depo-Medrol 2cc I.M. & Xylocaine I.M.

5. (a) WAS THE OCCURRENCE DESCRIBED IN YOUR INITIAL FORM C-48 THE COMPETENT PRODUCING CAUSE OF THE INJURY AND DISABILITY (IF ANY) SUSTAINED? [ ] YES [ ] NO

(b) DID YOU FILE AN INITIAL REPORT (FORM C-48) STATING HOW THE INJURY OCCURRED? [ ] YES [ ] NO IF "NO" ATTACH FORM C-48 TO THIS REPORT

FAILURE TO FILE FORM C-48 MAY INVALIDATE YOUR BILL

6. MAY THE INJURY RESULT IN PERMANENT RESTRICTION, TOTAL OR PARTIAL LOSS OF FUNCTION OF A PART OR MEMBER, OR PERMANENT FACIAL, HEAD OR NECK DISFIGUREMENT? [ ] YES [ ] NO IF "YES" DESCRIBE

7. WAS PATIENT HOSPITALIZED SINCE LAST REPORT? IF SO, WHAT HOSPITAL AND WHEN? [ ] YES [ ] NO

8. (a) ANY FACTORS DELAYING RECOVERY? IF "YES" DESCRIBE [ ] YES [ ] NO

(b) IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? IF "YES" GIVE DETAILS [ ] YES [ ] NO

(c) IF "YES" HAS REFERRAL BEEN MADE? (GIVE DETAILS) [ ] YES [ ] NO

9. FOR CHIROPRACTOR OR PODIATRIST: DOES THE ABOVE DESCRIBED INJURY CONSIST SOLELY OF A CONDITION OR CONDITIONS WHICH MAY LAWFULLY BE TREATED BY A CHIROPRACTOR OR PODIATRIST? [ ] YES [ ] NO — IF PHYSICIAN, HAS HE ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS CHOICE? [ ] YES [ ] NO

10. ENTER HERE ADDITIONAL PERTINENT INFORMATION, WORK LIMITATIONS, IF ANY, ETC.

unable to bend left elbow without pain

Date	Type or Printed Name of Attending Doctor	Address
4/17/81	Dr. Allen Josephs	26 Eldorado Dr., E. Northport, NY 11731

Web Address Code	WCB Authorization No.	Telephone No.	Written Signature of Attending Doctor (Facsimile Not Accepted)
N-DP	210980	499-2767	

C-4 (12-73) SEE REVERSE SIDE FOR SPECIAL INSTRUCTIONS

EXHIBIT No. 9B

DR. ALLEN [illegible]
26 ELDORADO DRIVE
EAST NORTHPORT, N. Y. 11731

#V595530

July 30, 1979

Hector Monthalvo
54 Elberta Dr.
E. Npt., N.Y. 11731

APPROVED
DIRECT
REIMB
POR $ 98.48
DATE 8-23-79
INITIAL

CHG.

FOR PROFESSIONAL SERVICES:

~~7-9-79~~	Examination	$9.90
	Depo-Medrol 2cc I.M.	9.77
~~7-13-79~~	Examination	9.90
~~7-16-79~~	"	9.90
	Depo-Medrol 2cc I.M.	9.77
~~7-20-79~~	Examination	9.90
	Depo-Medrol 2cc I.M.	9.77
7-23-79	Examination	9.90
7-27-79	"	9.90
	Depo-Medrol 2cc I.M.	9.77
		$ 98.48

MBG 043 case no A595530

Tax No - 455-44-5512
Dr. Josephs
Social Security

Mr. Cox. We went out and spoke with Mr. Monthalvo. We found out he did not first see Dr. Josephs in March 1978. He didn't see him until April or May. Apparently, Dr. Josephs backdated his billing.

For the first few months of his treatment, Monthalvo was treated by military and Public Health Service authorities. It was only later when he went to Dr. Josephs, his family physician, for another illness that Dr. Josephs suggested he switch doctors and begin seeing him.

Mr. Monthalvo indicated he had seen Dr. Josephs during the period of time 1979 to 1981, but that he only saw him on the average of once or twice a month, not twice weekly as billed by Dr. Josephs.

He indicated that he only received a maximum of 10 to 15 shots over this period of years, not the one-weekly shots indicated by Dr. Josephs.

It should be pointed out that all three witnesses returned to work within a reasonable period of time, commensurate with the seriousness of their injuries.

Furthermore, in each instance, Dr. Josephs continued to bill the Department of Labor without the knowledge of any of these witnesses.

We contacted Dr. Josephs through his attorney at the beginning of this month. We requested an opportunity to meet with Dr. Josephs, set forth our case, and obtain his explanation.

We have not yet received formal response from Dr. Josephs. However, his attorney advised me that his advice to Dr. Josephs would be that he not testify and that he should invoke his right not to testify with respect to self-incrimination.

Regarding our analysis of the susceptibility of the Department of Labor to schemes such as this, I would like to recount the kind of scheme that was utilized here. Billings indicate excessive treatments without any questions by the Department of Labor, no contact by the Department of Labor with the various claimants involved and no questions ever being asked by the Department of Labor as to the necessity for the treatments.

These suspicious criteria are similar to the ones that were seen with each of the doctors with regard to their non-FECA-related fraud schemes.

In Dr. Joseph's case, this scheme was not at all sophisticated. It was a simple scheme, able to fool the Department of Labor.

Ms. HAINER. Thank you. Mr. Chairman, I would first like to express that we did not simply review the files of Dr. Josephs and leave our file review at that. We were making onsite visits to the labor district offices in New York, in Boston, in two Washington, D.C. district offices, at which times we were reviewing claimant files. The files of Dr. Josephs' patients and his treatments simply typify the file situation which we found existed in all of the offices that we visited. In each file, we could find early warning signals that should have alerted the Department of Labor staff to these very unsophisticated fraud schemes. We found red flags, such as sloppy documentation of causalty and disability. We even found instances where a claimant would report an injury occurred in a certain way, that he injured himself in one part of the body, and his doctor would contradict that report, saying the claimant was injured somewhere else, yet the contradiction was never resolved by the DOL staff.

84-776 O - 81 - 3

No questions were ever raised. We found examples——

Chairman ROTH. May I ask you a question?

I understand that basically these cases were only reviewed by clerical help in the Department of Labor.

Ms. HAINER. Yes; it is very true.

Chairman ROTH. It is rather a routine type check?

[At this point, Senator Cohen withdrew from the hearing room.]

Ms. HAINER. This is what we later found out. Most of the cases we were reviewing, and in particular those of Dr. Josephs' patients, were cases in which the claimant lost 45 days from work or less. Therefore, the Department of Labor does not directly pay compensation benefits to these individuals. Their employing agencies cover the first 45 days. The routine practice in situations like this is for a claims examiner to initially accept the condition of injury or illness as reported by the claimant and doctor. The claimant is paid by the agency for the first 45 days lost from work and if the claimant returns to work any subsequent medical bills are handled by bill payment clerks, GS–2 and 3 level payment clerks. These clerks have authority to pay medical bills. In the New York regional office, for example, bill payment clerks pay out $2 to $3 million a month. And, as I will get into, we found little indications of close supervision of their work. We found lack of communication between the bill payment clerks and the claims examining staff. So for all intent and purposes, the files we were looking at in which medical bills continue to come in after workers return to work, the bills were moving from the mail room to bill payment clerks and checks were going back out through the mail room. There was never any intervention by a claims examiner or by supervising staff.

We found in many of the files we were looking at just the barest of probative medical evidence. There were cryptic medical reports, one-line statements, usually referring to a strain, sprain, or spasm, but nothing more specific than that. No narrative on the claimant's medical history was included. It was very difficult to tell whether the claimant aggravated a pre-existing injury or suffered an injury on the job in these medical reports because they were so cryptic.

The progress reports that were sent on the claimant diagnosis were equally as cryptic. As we saw in the case of Dr. Josephs' claimants, the reports usually repeated, down to the last word, previously submitted reports. We found other examples where progress reports never indicated when a claimant would be ready to return to work, the status of the disability, whether the disability had increased, whether it had decreased.

We wondered why a claims examiner or a Department of Labor staff person could not call up a claimant and ask, are you still receiving treatment, because we are still receiving medical bills. Why couldn't a Department of Labor examiner or supervisor call up the doctor and say, "You stitched and restitched a leg 283 times. Do you ever plan on removing the stitches?"

Senator RUDMAN. Let me interrupt for one moment at this point.

Could you explain to the subcommittee, if you will, the structural composition of the claims filed at that level of the office?

Let me tell you why I ask the question. Most insurance fraud that I am familiar with is discovered by mistakes within files which are kept in a fairly organized manner. In the case of the postal employee who had stitches, I believe, from June 10, 1976, week after week, his leg was stitched; well, obviously that is impossible. A claims file in most insurance carriers would reflect the preceding treatment and anyone who was, in fact, making the payment, even with the most rudimentary of training, would see that. Why wasn't that seen in this case? What was the status of the file itself? I wish you had a file here to show us. It would be interesting to see.

Ms. HAINER. Senator, we do have one file here. I believe I can illustrate for you, though, what the files typically look like. There would be a claims form submitted by the claimant first indicating the nature of injury, how it occurred. There would be a space on this form for the claimant's supervisor to write concurring or contradictory statements about how the injury occurred on the job. This would be the basis for which a determination would be made to accept the case as work-related injury. In the cases we were looking at, for the most part, the only other information in the file would be medical bills and medical reports.

Senator RUDMAN. Would there not be, in that file, however, a bill that showed stitching on such and such a date, so much money? Wouldn't every one of those bills be in that same file?

Ms. HAINER. Senator, all the medical reports are stored in the claimant's file. It is my understanding medical bills submitted prior to late 1978 are stored in the claimant's files. However, the Department of Labor implemented an automated bill payment system in late 1978. Now the bill payments are entered into a computer and the hard copy medical bill is stored not in the claimant's file, but in a storage area completely removed from the claimant's file and identifying number. It is very difficult to go back and retrieve this information.

There is an indication in the file, however, there is a tally sheet right on the inside cover of the file which summarizes payments made to date, to whom the payments were made, the amounts, and it has the signature of the bill payment clerk on it. At the very least a clerk could look at the summary sheet and realize that 280 payments were made to this provider, and could ask: Should we send this out to an examiner to question? Should we get our district medical director involved and ask the district medical director's opinion on the length of treatment supposedly rendered?

Senator RUDMAN. I can simply tell you from my own experience that it would be rare indeed for a private compensation carrier insuring industry in this country to ever have this kind of a thing happen because of the way they examine their claims file.

What you are telling me is the people who process this are really payment clerks and there are no checks and balances whatsoever in these field offices to prevent repayment for the same treatment, none at all.

Ms. HAINER. Unfortunately, that is what we saw.

Again, what we saw—this whole system has been called compensation by mail and I can only say that is exactly what we experienced. We saw papers moving no further than the mailroom to the bill pay-

ment clerks and you can actually see the trail by which the paper travels and it never goes any further than the bill payment clerks.

In the case of Dr. Richard Kones, which we referenced before, in which he allegedly treated one worker for $123,000 worth of services, there is one year in which he received $50,000 just from the Department of Labor, for this one employee. Another year, $60,000. This one file obviously contains a summary of all the payments made. Why were no questions asked about the repetitious nature of the bill submitted, the fact that one doctor is billing so much for one claimant, who has long since returned to work and who is not losing any time from work because of injury?

Senator RUDMAN. Mr. Chairman, if I may ask one further question at this point: Has the Department of Labor at that level started to explore or initiate some of the very sophisticated data processing programs which are now being incorporated by private insurance companies which essentially, by data processing sorting, spot the very kind of aberrations you are talking about and automatically alarm them to a high level supervisor? Is that being done?

Ms. HAINER. Senator, I would like to give you a two-part response to that question.

The first answer is we have been told that the automated system catches duplicate billings, catches excessive billings. I will, a little bit later on, give you an example where that was not the case.

The second part is—we were told before we actually went and talked with bill payment clerks, that the clerks are trained to read the bills. the medical reports, relate the treatment billed with the accepted injury condition. They are to make judgments about the necessity of treatment, the reasonableness of cost.

We were told that they are to use medical dictionaries, pharmaceutical directories, to look up drugs, to validate that the drug prescribed is one for which service is being billed and is related to the injury.

Senator RUDMAN. But you did not find any evidence of that being done?

Ms. HAINER. We dispute that. We actually witnessed bill payment clerks mechanically paying bills, rubber stamping bills.

We have indications that xerox copies of bills were submitted and paid as originals.

Senator RUDMAN. Thank you.

I didn't want to break the line of your testimony. But I did want to ask that question at that point.

Ms. HAINER. You just brought me further along more quickly.

These are the problems that we found and we were wondering why questions were never posed. Again, we disputed that these types of checks were made by the bill payment clerks and we disputed that supervisors monitor the work of bill payment clerks.

Just as an indication: Some of the treatment rendered by Dr. Josephs which involve weekly doses of injected drugs are those which a bill payment clerk, looking in a pharmaceutical directory, would have noticed that some of these drugs are very strongly advised to be given once as an injection and then, if continued treatment is needed, to be given orally. Why wasn't a question like this raised? We can only say that we don't think the questions ever occurred to anyone reviewing these files.

What we saw is that a bill comes in, it is paid sometimes for something as ridiculous as casting and recasting a sprained wrist 109 times. We have an indication where a claimant who sprained a finger and never lost any time from work, was supposedly seen 70 times by a treating physician. Why couldn't somebody have called up the doctor and asked when he thought the patient might recover from the sprained finger? Again, the checks just were not in place to even question this.

We were told that the Department of Labor maintains one control over medical bill payment, and that is to approve a claimant's switch in physicians. Let me just backtrack and say that claimants are allowed the right to choose a physician of their choice, but if they switch doctors during the course of their treatment, that switch must be approved by the Department of Labor.

In many files we looked at, we saw that claimants were initially treated by one physician and, for whatever reason, decided to switch to another doctor. There were never any approval forms in the files. We have indications in some of Dr. Josephs' cases that Dr. Josephs was the second treating physician. Payment never stopped. It just continued, but it went to Dr. Josephs. His bills were never questioned. This not only raises the question in our minds of how the switch in physicians is monitored by the Department of Labor and approved by the Department of Labor, but it raises the whole question of doctor shopping by claimants. We find in several files we looked at, claimants who, first reported by their physician to be totally capable of working full time, later find a doctor sympathetic to their cause and they continue on disability, sometimes for years. Yet no questions were ever raised about contradictory medical evidence in the file, or disputing opinions between physicians.

We also were told that the second check the Department exercises is to call for second impartial medical opinions by Board-certified specialists in cases where there is a question about the claimant's degree of disability or the physician's treatment rendered.

We have one example that I would like to bring to your attention, and it involves Mr. Monthalvo, whose case we just heard about.

Mr. Monthalvo was treated, as we heard, for several years for an inflamed elbow. In June 1979, his case finally came to the attention of the claims examiner who questioned the length of treatment.

At this time, I would like, with your permission, Mr. Chairman, to introduce exhibits 9C and 9D.

Chairman ROTH. Without objection.

[The documents referred to were marked "Exhibits 9C and 9D" for reference and follow:]

EXHIBIT No. 9C

U S DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

MEDICAL OPINION

DOCTOR

BRANCH OF CLAIMS AND BENEFIT PAYMENTS

The OWCP Accepts the Following as Factual: File No. A2-395530

Claimant age 49 yrs., working as an Elec. Equip. Repairer on 2/28/78 was getting down from on top of a bull dozer, when he stepped on a bench, which moved, causing him to fall on his left elbow. Is treatment being furnished by Dr. Allen Josephs, necessary and for such a prolonged period of time.
Please check the appropriate reply: X Yes ____ No

IF POSSIBLE IN THE SPACE PROVIDED BELOW, PLEASE EXPRESS YOUR OPINION AND/OR ANSWER THE ITEMS CHECKED. IF THE SPACE PROVIDED IS INSUFFICIENT, PLEASE USE A SEPARATE SHEET AND NUMBER EACH ITEM TO CORRESPOND WITH THE NUMBER ON THIS FORM.

☐ 1. Was the condition or disability reported or found on examination of _____ due to precipitated, accelerated, aggravated, or proximately caused by the accepted injury or conditions of employment?

☐ 2. Is the diagnosis established? State diagnosis.

☐ 3. Give date medical evidence shows termination of total disability. _____

☐ 4. Give date of maximum medical improvement and degree of permanent impairment as an individual. _____

☐ 5. Is the permanent partial impairment of the _____ the SOLE permanent impairment resulting from the injury?

☐ 6. For schedule award purposes indicate permanent functional loss of use of _____ _____ and date maximum improvement obtained.

☐ 7. Should the claimant be examined by a specialist?

☐ 8. Recommendations if indicated. Refer case to board Certified orthopedic Physician for Evaluation

☐ 9. Give detailed discussion of the medical opinion (surgery, technical or complicated cases).

☐ 10. State professional qualifications of Dr. _____

☐

☐

R. Ruhnenberg — Examiner — 6/6/79 — Date

_____ — Claimant's Signature — Date

Form CA-5g
Rev. May 1978

EXHIBIT No. 9D

June 17, 1981

A2-395530
Employee: Hector Monthalvo
DOI: 2/28/78

Dr. William A. Healy
196 East Main Street
Huntington, NY 11743

Dear Dr. Healy:

We are asking the employee named above to contact you for an appointment to evaluate his elbow condition.

Mr. Monthalvo sustained a work-related injury on 2/28/78 and was disabled for a three month period. This office accepted his condition as contusion and myositis of his left elbow.

He has been receiving bi-monthly medical treatments from that date to present.

We would appreciate a detailed medical report including a firm diagnosis, findings, and prognosis. In particular, we would like your opinion as to whether he is being treated for a condition related to his 2/28/78 injury. Please include any comments or recommendations.

To expedite payment for your services, it is suggested that you submit your bill on the enclosed CA-1333.

Your services are appreciated in advance. Thank you.

Sincerely,

Karl Anderson
Claims Examiner

Ms. HAINER. These exhibits show that in June 1979 the claims examiner asked the district medical director to recommend a course of action for Mr. Monthalvo because it was felt that treatments were becoming excessive. The district medical director agreed, recommended that Mr. Monthalvo be sent to a Board-certified orthopedic specialist for a second opinion exam. Exhibit 9D shows that in June 1981, fully 2 years later, Mr. Monthalvo's case was finally referred by letter to a Board-certified specialist to render a second opinion.

I would like to mention that the date this letter was sent out was the exact date we were in New York reviewing his file. It is the date upon which we noticed no action had been taken on the case, brought it to the attention of the claims examining staff in New York. It is our understanding that the second examination has never in fact taken place.

Please keep in mind that during the 2-year period from 1979 until 1981, after questions had been raised about Dr. Josephs' bills on behalf of Mr. Monthalvo, Dr. Josephs continued to be paid when he billed for week-in and week-out treatments.

It seemed as though the bill payment clerks and the claims examining staff of the New York office, in the case of Mr. Monthalvo, were operating on two different wavelengths. They were not communicating, somehow word had never been passed down that there was a question about excessive medical treatment of this case.

Senator RUDMAN. Could I ask a question about one of these exhibits, Mr. Chairman?

Chairman ROTH. Sure.

Senator RUDMAN. This is exhibit 9C.

Ms. HAINER. It is the letter to Dr. Healy?

Senator RUDMAN. No; the form that says "Medical Opinion." This is dated June 6, 1979. What was the date of initial treatment in this case?

Ms. HAINER. The date of initial treatment was February 1979—1 year later.

Senator RUDMAN. And the examiner in this case checks that the treatment is necessary for that prolonged period of time.

Ms. HAINER. The examiner sends a note to the district medical director summarizing the case and says, "Is treatment being furnished by Dr. Allan Josephs necessary and for such a prolonged period of time?"

At the bottom, No. 9, you will see where the district medical director wrote, "Refer case to Board-certified orthopedic physician."

Senator RUDMAN. I understand that, but the examiner in the first instance checked the box yes; is that correct?

Ms. HAINER. "Please check for appropriate reply"—what that means is the district medical director says, "Yes, it is possible such prolonged treatment is necessary, but let's refer out for a second opinion."

Senator RUDMAN. All right.

Ms. HAINER. And, again, this is a point I would like to stress, that the Department of Labor, because of the fact that claimants have the right to choose their treating physician, feels that it cannot make a decision about the necessity of treatment. There must be a second opinion on this.

Senator RUDMAN. Thank you.

Ms. HAINER. District medical directors, as we just mentioned, are staff Department of Labor people who are supposed to provide expertise to the claims-examining and bill-payment staff. There are 16 Department of Labor compensation offices across the country and each office is supposed to have at least one medical director.

We found, however, there were some offices in which that position had not been filled. Where there was a district medical director in place, the medical director was overworked with reviewing cases.

In New York the medical director reviews 400 cases per month. The district medical director can only recommend courses of action to the claims examiners. The examiners then must follow through, and the district medical directors only see those cases which are brought to their attention by the claims examiners or the bill-payment clerks.

We were also told that the district medical directors are supposed to provide advice on the necessity of prolonged treatment and the reasonableness of medical costs.

What we found was that there has been absolutely no definition ever promulgated by the Department of Labor on what constitutes a reasonable medical cost.

There have been fee schedules developed, there are provider utilization reports which are in use industrywide. But in the FECA program, the doctor bills the Department of Labor and is paid 100 percent of whatever he bills. The Department of Labor made no attempt to assess whether one doctor in one locale is treating more than another doctor in the same locale or billing at higher rates.

We were told that the Division of Medical Services and Standards at the national office was responsible for developing guidelines such as this and other medical guidelines which the district offices need to adjudicate claims. However, we heard many complaints out in the field that this Division of Medical Services and Standards at national has been largely inactive and has not promulgated any guidelines, any medical evidence guidelines. In fact, in 1975, the Department of Labor's own internal effectiveness study critiqued the fact that medical claims in fully one-third of the cases may be unwarranted; yet 6 years later we found no action taken to address this situation.

The lack of controls in monitoring costs, the lack of efforts to contain medical costs, bring me to a situation in February 1981 in which the Department of Labor's own Inspector General Office issued a report critiquing the bill-payment operation at one district office. I do want to note the Inspector General made it a point to say that while this was an in-depth review of one district office, all of the situations found could apply to any of the district offices across the country.

Many of the lack of monitoring controls that we noted were also noted in this report. In fact, the Inspector General asked that the Department of Labor implement a fee schedule. The staff report actually went to the Department of Labor in the summer of 1980 as a draft.

At that time, Labor commented they would develop fee schedules and guidelines within 3 months. We went to the Department of Labor in May of 1981 and again in June of 1981. The first time we went we were told that fee schedules were impractical to use and could not be developed. Therefore, they would not be developed.

In June of 1981, we were told that fee schedules would be identified and they would be built into another stage of computer capability which should be in place, we were told, in October of 1984.

Chairman ROTH. Isn't it true that medicaid and medicare have fee schedules?

Ms. HAINER. Yes, Senator, it is an industrywide practice.

Chairman ROTH. Is there any reason, any peculiarity in this particular program that these fee schedules could not be used as an example or precedent?

Ms. HAINER. Absolutely not; the injuries are no different.

Chairman ROTH. So it appears to be a lack of will to do anything?

Ms. HAINER. It appears that there has been no effort to come to grips with the rising medical costs and the need for medical cost containment.

Chairman ROTH. Please proceed.

Ms. HAINER. Let me mention that this Inspector General's report from February 1981 was not simply a systematic review of one district office. The report came about because of a loss that occurred at this district office.

One of the Department of Labor's own program employees misappropriated $50,000 in bill payment funds. This was done by manipulating and making up fraudulent medical provider bills, and then having the checks sent to the employee's boyfriend's account. This went on for a period of time. The scheme was not uncovered by the Department of Labor. It was actually first discovered by the employee's own banks. They became suspicious of the large number of Government checks deposited and called the Secret Service to investigate. This employee, we are assured, was fired from the Department of Labor Compensation Office—1 day before charges of larceny were brought.

This points out how easily manipulated the computer system is. We found this to be the case in another area. We have been told the Department of Labor's new computer system which had been implemented to handle bill payments on an automatic basis would solve all their claims processing problems. The Department of Labor testified before the House Government Operations Committee in May of 1981 that their computer was fully in place and was providing timely, accurate data. Yet we found that this computer and the data it gave to us was the largest stumbling block in our investigation.

When we first began our investigation, we assumed it would make sense to find out from the Department of Labor how much money they were paying out in fiscal year 1980 to medical providers.

We wanted the information broken down by district offices. We were told we could have the information overnight. We were advised 4 weeks later that the information had just become available because a program had to be written into the computer to give us that basic management information. We got a set of statistics. We were called that same day and told to discard those statistics, that they were discovered to be inaccurate. We subsequently were given another set of statistics which we are assuming to be accurate.

We also found that we were unable to ask the computer to tell us to whom these payments were being made. If you have a doctor, you cannot put the doctor's name into the computer and get a rundown on how much the doctor has made from participating in FECA. What you must do is find out the doctor's Internal Revenue Service employee identification number. For some arbitrary reason, Labor has decided

that they will track doctors through their system by this EIN number, this identification number.

Of course, we could not get, in the case of Dr. Josephs for example, this number from the Department of Labor directly. That didn't seem to be possible. We had to go to the Postal Inspection Service and ask them to come up with a number for us. They were able to track a number that Dr. Joseph used, I believe, from some of his Blue Cross-Blue Shield bills. We gave this number to the computer and we in turn were given a printout indicating that Dr. Josephs treated 20 Federal claimants and he made $22,000 from participating in FECA.

When we went out and actually reviewed his files, we found that the amount of money he received from FECA participation was closer to $50,000 from late 1975 through 1978. The discrepancy can be explained two ways. One is that the information stored in the computer dates from 1978 to the present only. So if Dr. Josephs was treating a patient from 1975 to 1977, that information would not be stored in the computer, you would have to go to the file to tally it up. But, more importantly, we found that doctors use more than one employee identification number and the Department's own system does not cross-reference or edit this information to give one report on how much money is accrued to the doctor.

In the case of Dr. Josephs, we found that he used five employee identification numbers and we found this by actually going through the files. As a matter of fact, as of last week, we were told there has been another number with which he is associated. In the case of Dr. Kones, we found that he used five employee identification numbers, too. Each time a new number is discovered, there is a possibility of discovering more money paid to the physician and new cases in which the doctor is treating Federal workers.

None of this information is cross-referenced or edited. All we can say with any degree of authority is that every time we went back to check the data base, and we did this several different ways, we got a new set of statistics and each time the statistics contradicted previously retrieved information.

We can state that Dr. Josephs treated 20 Federal claimants and that he made $50,000 from 1975 through 1978, but we cannot say whether $50,000 is the pinnacle of his FECA earnings or whether it is just the base upon which more money rests.

Another problem, as you already alluded to, Senator Rudman, is the fact these hard copy medical bills are not stored in the file. It becomes very hard to reconstruct a payment history, reconstruct the exact service dates, reconstruct the exact treatment supposedly rendered. We had great difficulty in trying to retrieve this information. It has taken 4 weeks for the district office in New York to pull together the hard copy medical bills on just three cases and to date they have not been able to completely reconstruct any of the three payment files.

These hard copy medical bills are terribly important in tracing duplicate payments. We have indications that one physician was paid $5,000 twice on 1 day. We don't know whether this was duplicate billings on the physician's part or whether this was an error by the bill payment clerks. No one, not even the automated system, caught this.

I want to stress that this happened after the computer system was in place.

We have another instance of duplicate billings in which Dr. Josephs was the treating physician. He treated a VA employee who sustained cervical strain. We knew from his earlier administrative disqualification from medicaid in New York that this particular claimant had been concurrently a medicaid patient of Dr. Josephs. We pulled this claimant's file and were able to establish that there are some instances of duplicate billing.

At this point, I would like to submit exhibits 10A, B, C, and D, with your permission.

Chairman ROTH. Without objection.

[The documents referred to were marked "Exhibits Nos. 10A, B, C, and D," for reference and follows:]

EXHIBIT No. 10A

STATE OF N[illegible]

WORKMEN'S COMP[illegible]TION BOARD

ATTENDING PHYSICIAN'S 48-HOUR REPORT

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED
		3-17-75	V A Hospital Northport, New York

INJURED PERSON	NAME [illegible]	AGE 22	ADDRESS 29 Leigh St., Huntington, N.Y.
EMPLOYER	V.A. Hospital		Northport, New York
INSURANCE CARRIER	U. S. Govt.		1515 Broadway, N.Y.C., N.Y.

HISTORY

1. State how injury occurred and give source of this information. (If claim is for occupational disease, include occupational history and date of onset of related symptoms).

While picking up laundry bag was thrown backward. Injuring left side of neck, left shoulder & mid back.

2. Is there a history of unconsciousness? [ ] YES [X] NO — If "Yes," for how long? — Were X-Rays taken? [X] YES [ ] NO

3. Was patient hospitalized? [ ] YES [X] NO — If "Yes," state name and address of hospitals

4. Was patient previously under the care of another physician for this injury? [X] YES [ ] NO — If "Yes," enter his name and address, and reason for transfer under "Remarks" (Item 10).

DIAGNOSIS

5. Describe nature and extent of injury or disease and specify all parts of body involved.

Cervical sprain, myositis lft shoulder & thoracic myositis

TREATMENT

6. Nature of treatment: Manipulation, Diathermy & Robaxin I. M. & orally

Date of your first treatment: 3-20-75 — If treatment is continuing, estimate its duration: 1 week

If treatment is not continuing, is this your final report? [ ] YES [ ] NO — If "Yes," state date of last treatment

DISABILITY

7. May the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent facial, head or neck disfigurement? [ ] YES [X] NO

8. Is patient working? [ ] YES [X] NO — Is patient disabled? [X] YES [ ] NO — If "Yes," estimate duration of disability: 1 - 2 weeks

CAUSAL RELATION

9. In your opinion, was the occurrence described above the competent producing cause of the injury and disability (if any) sustained? [X] YES [ ] NO

REMARKS

10. Enter here additional information if value, requests for authorization, etc. V.A. Hospital Doctor Northport

10. (a) Medical testimony is occasionally required. If your testimony should be necessary in this case, please indicate the days of the week (and hours) most convenient to you for this purpose: Tuesday 9-11 A.M.

Dated	Typed or Printed Name of Attending Physician	Address
3/12/75	[illegible] Josephs	26 Alameda Dr., Flint, N.Y.
WCB Rating Code	WCB Authorization No. / Telephone No.	Written Signature of Attending Physician
[illegible]	[illegible] / 26-7767	[signature]

C-48 ANSWER ALL QUESTIONS. AVOID USE OF INDEFINITE TERMS

EXHIBIT No. 10B

STATEMENT

864-2767

DR. ALLEN JOSEPHS
26 ELDORADO DRIVE
EAST NORTHPORT, N. Y. 11731

AUG 5 1975 19 9

7/7 75

Diana Scruggs
29 Cuyler St.
Huntington

DIRECT PAYMENT APPROVED
FOR $ 70.50
DATE 7/11/75
INITIAL KH

FOR PROFESSIONAL SERVICES: Diana Scruggs

6/20/75 - Manipulation 35
Robaxin 7½ 35

6/23/75 - Manipulation & Diathermy 75
Robaxin 35

6/27/75 - Manipulation & Diathermy 75
Robaxin 35

7/1/75 - Manipulation & Diathermy 85
Robaxin 35

7/5/75 - Manipulation & Diathermy 85
Robaxin 35

7/7/75 - Manipulation & Diathermy 85
Robaxin 35
70.50

EXHIBIT No. 10C

STATE OF NEW YORK — HEALTH PRACTITIONER SERVICES

41 SUFFOLK 144776

Diana Scruggs — Diana Scruggs — 10 31 44 — 01 2

PROVIDER NO. 5780076 — PROVIDER NAME: DR. Allen Josephs

DATE OF SERVICE Mo.	Day	Yr.	DESCRIPTION OF SERVICE	DIAGNOSIS/ATTENTION	Place of Service Code	Units of Service	PROC. CODE	AMOUNT $	ASSIGN. BAS Office
6	24	75	examination + diathermy	Cervical Strain	0	1	9000	7.50	1
6	24	75	Robaxin T.M.	Cervical Strain	0	1	9049	3.00	1
6	27	75	examination + diathermy	Cervical Strain	0	1	9001	6.00	1
6	27	75	Robaxin T.M.	Cervical strain	0	1	9049	3.00	1

19.80
19.80

265962 MR

EXHIBIT No. 10D

PATIENT NAME: Diane Scruggs	Date of Service	Billed Amounts CHAMPUS	Billed Amounts MEDICAID	
TREATMENT EACH VISIT				1
Examination, manipulation & Heat	6/27/75	11 25	9 00	2
Treatment - injection of muscle				3
relaxant				4
	7/1/75	11 25	10 00	5
	4/5/75	11 25	9 00	7
	3/25/75	11 25	8 00	9
				10
	3/28/75	11 25	9 00	11
				12
	4/7/75	11 25	10 00	13
	4/11/75	11 25	9 00	14
	5/12/75	11 25	9 00	15
	6/13/75	11 25	9 00	16
	7/1/75	12 25	9 00	17
	7/25/75	12 25	9 00	18
	12/24/75	12 25	9 00	19
	1/1/76	12 25	9 00	20
	3/26/76	12 25	9 00	21
	4/2/76	12 25	9 00	22
	4/9/76	12 25	9 00	23
	4/23/76	12 25	9 00	24
	5/7/76	12 25	9 00	25
	5/14/76	12 25	9 00	26
	5/21/76	12 25	9 00	27
	5/28/76	12 25	9 00	28
	6/1/76	12 25	9 00	29
	6/4/76	12 25	9 00	30
	6/11/76	12 25	9 00	31
	6/18/76	12 25	9 00	32
	6/25/76	12 25	9 00	33
	6/28/76	12 25	10 80	34
	7/2/76	12 25	9 00	35
	7/6/76	12 25	10 80	36
	7/9/76	13 00	9 00	37
	7/20/76	13 00	10 80	38
	7/23/76	6 00	9 00	39
	8/6/76	13 00	10 80	40
	8/13/76			41
	8/20/76		9 00	42
	9/3/76		10 80	43
	9/13/76		9 00	44
TOTAL COST		538 75	540 40	45
ollects billings				46

EXHIBIT No. 10D—Cont.

PATIENT NAME: Diane Scruggs	Date of Service	Billed Amounts CHAMPUS	Billed Amounts MEDICAID	
TREATMENT EACH VISIT				1
Examination, manipulation & Heat	6/27/75	11 25	9 00	2
Treatment - injection of muscle				3
relaxant				4
	7/1/75	11 25	10 00	5
	4/5/75	11 25	9 00	7
	3/25/75	11 25	8 00	9
				10
	3/28/75	11 25	9 00	11
				12
	4/7/75	11 25	10 00	13
	4/11/75	11 25	9 00	14
	5/12/75	11 25	9 00	15
	6/13/75	11 25	9 00	16
	7/1/75	12 25	9 00	17
	7/25/75	12 25	9 00	18
	12/24/75	12 25	9 00	19
	1/1/76	12 25	9 00	20
	3/26/76	12 25	9 00	21
	4/2/76	12 25	9 00	22
	4/9/76	12 25	9 00	23
	4/23/76	12 25	9 00	24
	5/7/76	12 25	9 00	25
	5/14/76	12 25	9 00	26
	5/21/76	12 25	9 00	27
	5/28/76	12 25	9 00	28
	6/1/76	12 25	10 80	29
	6/4/76	12 25	9 00	30
	6/11/76	12 25	9 00	31
	6/18/76	12 25	9 00	32
	6/25/76	12 25	9 00	33
	6/28/76	12 25	10 80	34
	7/2/76	12 25	9 00	35
	7/6/76	12 25	10 80	36
	7/9/76	13 00	9 00	37
	7/20/76	13 00	10 80	38
	7/23/76	6 00	9 00	39
	8/6/76	13 00	10 80	40
	8/13/76			41
	8/20/76		9 00	42
	9/3/76		10 80	43
	9/13/76		9 00	44
TOTAL COST		538 75	540 40	45
ollects billings				46

Ms. HAINER. These exhibits indicate the claimant was treated by Dr. Josephs, that the claimant was treated on a particular day. This was one example, June 27, 1975. We also have a copy from the medicaid records of a bill sent by Dr. Josephs, again for treatment on June 27, 1975. We have been able to trace 37 instances of duplicate billings and we are able to show that the Department of Labor paid over $450 to Dr. Josephs on behalf of this claimant at the same time that he billed medicaid over $300 for this claimant—same injury, same dates of treatment.

If, Mr. Chairman, the Department of Labor were able to strengthen its computer capabilities, if they stored the hard copy medical bills with the files, if they were able to take care of duplicative billings, if they contacted claimants, perhaps by audit letters to let them know for what treatments their doctor was billing the Department of Labor, if they spoke to claimants to verify information on the claims forms we still don't believe that the workers' compensation program would be impenetrable to fraud, waste, and abuse.

The Department of Labor feels that it is powerless to exclude practitioners from their programs unless these providers lose their medical licenses. It is not a new concept that a professional license does not insure honesty. But somehow the Department of Labor has failed to grasp this concept and in doing so, they just open tnemselves up to further waste and fraud.

Chairman ROTH. What rationale do they give you that they are helpless and can do nothing?

Ms. HAINER. The FECA regulations state that the Secretary of Labor shall determine who is a qualified physician for participation in the program. The definition of a qualified physician is a doctor who meets the professional licensing requirements of the State.

Chairman ROTH. These regulations are issued by the Department of Labor; are they not?

Ms. HAINER. Yes; by the Secretary of Labor who has the authority to determine the qualifications.

Chairman ROTH. So the Department of Labor has the authority to remedy that situation if they found that appropriate?

Ms. HAINER. Yes; we are not talking about—we haven't even touched on the cases where there is a question about the doctor in terms of the type of treatment rendered. We are talking about cases in which doctors have past histories of abusive practices in other governmental programs.

We are talking about doctors who have felony convictions for medical fraud.

These doctors are still allowed to participate in FECA. We are talking about Dr. Dent, Josephs, and Kones—all of whom have prior histories of either Federal offenses or administrative debarments in Government programs, yet they are perfectly eligible to continue practicing FECA because their licenses have not been revoked.

Chairman ROTH. But as I understand what you are saying, the Department of Labor, when you asked them why they weren't doing something about these doctors found guilty of fraud, their excuse, their rationale was because of the regulations that were issued by the Department of Labor?

Ms. HAINER. Right. By the Secretary of Labor.

Chairman ROTH. By the Secretary. So that in fact within the Department there was authority to correct this situation if there is anyone that had the desire to do so?

Ms. HAINER. There is the authority to define a qualified physician. It is our point that employees are entitled to choose their own physician, but the Government does not need to pay when a convicted felon is chosen as the treating physician.

Chairman ROTH. Please proceed.

Ms. HAINER. That concludes my comments, Mr. Chairman.

Chairman ROTH. Let me start out by saying that as you described the system, or lack of system, it seems to me that there is an open invitation to defraud the Government, that if you are going to characterize the internal controls, the management system that there was none. It is almost a total lack. Am I correct on that?

Ms. HAINER. Yes.

Chairman ROTH. I also would understand from what you say that the only line of control to the extent there is any are by the clerks, the GS–2, the GS–3, who earn roughly $8,000 or $9,000.

Ms. HAINER. Yes.

Chairman ROTH. That the district offices are characterized by the lack of qualified supervision as you would find in the insurance industry to, first, verify the claims; second, to monitor the payments thereafter.

Ms. HAINER. The bill payment clerks as I said in the district offices have total and complete authority to pay out medical bills and, just to illustrate, in New York $2 or $3 million per month is paid out on medical bills alone. Most of the time these bills are never routed to the attention of a claims examiner or medical director for opinions as to the propriety of the bills or the reasonableness of the cost.

Chairman ROTH. But I would like, before I go back to some of the specific cases, to ask you, despite the fact that there was no supervision and very little medical expertise available within these districts, nevertheless it should have been possible within these files to see that there were fraudulent claims being made. In other words, when you had 200 or 300 claims for payment by the provider in the case of the need that should have been obvious to the file clerk.

Ms. HAINER. It should have been. The only point that I could make is that apparently some bills or at least it seemed to us that some bills, were paid although the claimant's file was not even pulled up or reviewed at the time the bill was paid.

It seems those bills were just paid as they came into the office. There is pressure on these offices to pay bills in a timely manner. But one has to wonder about the necessity of paying at the expense of quality review.

Mr. Cox. I should point out that with regard to the case of Mr. Giannino, who was restitched time and time again, we confronted the district medical director in New York and asked him how this kind of case could be paid. We showed him the file. The first thing he indicated was he had never seen the file. The second thing he stated was that no one had ever bothered to read the information contained in the reports because, obviously, it would have raised some questions.

Chairman ROTH. Did you discuss the matter with the supervisors within that office? Why was that not brought to the attention of the medical director?

Mr. Cox. Given the press of work, nobody had the time to sit down and do an adequate examination of the file.

Chairman ROTH. How much time does it take to review that kind of file when you have 200 claims? Does that take a lot of time?

Mr. Cox. Not that much, sir.

Chairman ROTH. That is just an alibi, isn't it?

Mr. Cox. I would believe so.

Chairman ROTH. It is my understanding from your testimony, we have these three cases of doctors, let's take Dr. Kones for example, who had submitted $123,000 billed to the Department of Labor, for $123,000 for treating one Federal worker who sustained two on-the-job injuries between 1975 and 1979.

Dr. Kones was convicted of medicare fraud and medicaid fraud. He is currently under indictment in Westchester County, N.Y., on 22 counts for filing false claims with his own disability carrier, and $75,000 in bad check offenses in Texas. Do I understand that this man is still eligible to be provided medical services to people under FECA?

Mr. Cox. Absolutely, sir. There has been no effort whatsoever to restrict his eligibility in this regard. The only adverse impact upon his license was in his medicaid conviction in Connecticut in 1980 where he agreed, as a condition of his probation, not to practice medicine in Connecticut.

The Connecticut authorities never took any action on his license. He was still licensed to practice in New York. When he was convicted in 1974 his license was only suspended in that State for 6 months.

Chairman ROTH. Can we rationalize that these cases that you just cited are merely abberations, exceptions to the rule, that somehow they slipped through because of the volume of work? Is that the excuse?

Mr. Cox. No, sir, I would contend respectfully that these three examples are merely the tip of the iceberg and I would offer three points in support of that conclusion. First, each of these files indicate a pattern of sloppy bill processing. Our observations lead us to conclude that nobody is reading the medical files. If they do, nobody pays any attention to them. The easily detected fraud patterns of overtreatments, excessive amounts of money, long-extended periods of treatment for minor injuries were not just reflected in the case files of these three doctors. They were reflected in virtually every case file of every doctor we reviewed in Boston, New York, and the District of Columbia. This is endemic to the entire system.

Second, where in other programs the Federal Government does make attempts to identify fraudulent doctors, that information is never transferred over to the Department of Labor.

I hope we have been able to prove to your satisfaction here today that a doctor defrauding medicaid could have well been defrauding FECA.

According to the Health Care Financing Administration, which monitors medicare and medicaid fraud, they have identified 153 medical service providers who have been convicted of medicare fraud and medicaid fraud since 1977.

None of the files on any of the doctors has ever been checked against FECA to determine whether or not they have or are still doing fraudulent billings with FECA.

The third point I would make is that in addition to criminal convictions there are administrative exclusions from these programs. The Health Care Financing Administration can administratively exclude a doctor for abusive practices, similarly State workers' compensation programs can exclude doctors.

Of course, none of this information is tracked by the Department of Labor, either.

Senator COHEN. They can also reduce the payment under the Health Care Financing Act.

Mr. Cox. That is correct.

Senator COHEN. But there is none of that here?

Mr. Cox. Of course not. I would point out that as an experiment we contacted the New York Workers Compensation Board and they identified six doctors whom they had administratively barred within a year, 1980 to 1981, for abusing the State workmen's compensation system. We then took those six doctors, none of which were doctors mentioned here today, and found out that four of the six were practicing FECA doctors.

Again, there is no attempt to find that information, to track it, and then administratively apply it to FECA participation.

Chairman ROTH. Listening to your testimony it would seem like a total lack of interest in imposing any controls. It is at best gross neglect, as I understand your testimony. It seems to me there is a problem and I think rightfully they could be concerned about paying these claims promptly, because those employees who have bona fide claims need to be paid quickly because they need the funds then.

But it is the problem, that the only interest is shoveling the money out so to speak, but no one exhibits a concern to make certain that the claims are properly paid?

Mr. Cox. I would say that is a fair summarization of the point.

Chairman ROTH. Senator Cohen?

Senator COHEN. May I go back to the procedure? As I recall, in State workmen's compensation practice, you tend to have the same attorneys, the same doctors, the same physicians who show up at the hearings once every 2 weeks or once a month. It tends to be a fairly closed society.

[At this point, Senator Roth withdrew from the hearing room.]

Senator COHEN. In other words, most physicians are either too busy or have a practice which doesn't compel them to have to go across town in New York to appear at a worker's compensation hearing room, and sit in line and wait for 200 cases to be disposed of during the course of the day. There are certain physicians who do predicate their practice principally upon a worker's compensation-type of program.

Have you found evidence of that in Federal workers' compensation as well?

Mr. Cox. Yes: for example, there is one doctor, well-known within the District of Columbia, who deals in local workmen's compensation. He billed over $100,000 last year in FECA compensation, both with regards to his local work and his FECA work.

There have been suspicious questions raised. Can he do this volume of work? Can he fairly and adequately treat these people? No one has answered the questions.

Senator COHEN. The facts that you relate here are shocking on their face. We can sit up here horrified and say how in the world can we allow this kind of patent abuse to occur? But it has been occurring. It is not confined to this particular program. I think you talked about the lack of transferability of records. We find that endemic throughout our whole system where we have one agency who actually makes a finding of fraud and abuse on a firm, debars that firm from doing business, and then that firm goes across the street, going from one agency to HUD, let's say, and gets another contract. They have no master list.

They do not circulate it on any regular basis. There is no binding nature to it. The Department of Defense is totally excluded from it and resisted any attempt to even be bound by or presumptive of another agency's debarment proceeding.

Now we come to the question of how do we get a handle on it? What do we do to try to find methods of controlling this? One, as you have suggested, is that we upgrade the level of the people who are reviewing the files. That may or may not be prohibitively expensive. I tend to doubt it would be that expensive, but that may not be the best answer.

It occurs to me that it would not be terribly successful for example to have the patient or the injured employee be given copies of the periodic statements of the services he has been allegedly rendered.

That might involve a substantial amount of paperwork but maybe the paperwork would be worth it in that case except for the following fact. If you have an ongoing physician-client or patient relationship, it seems to me that that patient is in a very difficult position if he is called upon to review the adequacies of the services or indeed whether the services have been performed if in fact he does have a complaint and does have a continuing relationship, because that physician could then reassess his disability.

In other words, if someone is assessed at being 75 percent disabled on a period of 6 to 8 weeks, has a chronic low-back problem, and then receives a slip from a Federal agency asking "do you agree with the services that have been rendered and that the costs for those services, and do you agree with that statement," he is put in a difficult position because then the physician might, in retaliation, I suppose, downgrade that disability from 75 percent to 10 percent, or whatever.

So I am not sure that is going to be the proper solution to the problem. What occurs to me is why is there not some sort of mandatory review procedure. For example, if you do in fact have a finding, you must have administrative hearings, and there has to be a finding of a causal connection between a work-related injury and, in fact, the disability or the treatment that is required. There has to be a causative factor established. Why is there no procedure here for, say, a 6-month review by the appropriate administrative agency that these services have, in fact, been provided? Also, why not bring the patient in for review, and update, and make that person carry the burden, showing that the services have been rendered, have been essential and that their continuation is required?

Why is there no such procedure?

Mr. COX. Such procedure is in effect right now. Very recently the Department of Labor commenced a program whereby, those cases on the periodic rolls, will be subjected to an annual review.

Additionally on paper, every time a bill comes in there is supposed to be some sort of review of the file to determine the appropriateness of the treatment.

This requirement is on paper. The question is whether or not in the practice the rules and regulations and the policies are being carried through. Labor will testify, I am certain, that they have removed many people from the periodic rolls, but the fact remains that in all files we had an opportunity to review, we did not see any record of those periodic roll reviews touching on the cases we looked at.

If it was being done, and I do believe it is being done, it is not being done adequately enough or intensively enough.

Senator RUDMAN. Have you either, given the experience in the private insurance field in the area of compensation processing or in the alternative, had an opportunity to go back and look at the operation of major insurance companies which are handling volumes in some cases equivalent to what is handled by Department of Labor?

Ms. HAINER. We did go see private insurers who worked with compensation in the private sector. We also visited a private insurer to see how they handled their daily compensation processing. We found a completely different attitude. We, on the one hand, were told by the Labor Department that they felt constrained by their understanding that the workers compensation laws must be construed in favor of the worker.

Therefore, they do not feel that they can verify the claims, that they can validate treatment rendered. In fact, I was told on more than one occasion by examiners that claims verification was a conflict of interest for the claims examiner.

Senator RUDMAN. Would you repeat that? I don't understand that.

Ms. HAINER It was a conflict of interest for the claims examiner at Labor to investigate a claimant.

Senator RUDMAN. Who told you that?

Ms. HAINER. Claims examiners at district offices.

Senator RUDMAN. I don't need it for now, but do you know who those examiners were? Do you have records?

Ms. HAINER. It was the Boston and New York regional offices.

Senator RUDMAN. I would like to have you supply that for the record. I would like to know who told you that. I believe we ought to go into a short break here, shortly recess so Senator Cohen and I can go over and vote and come back.

[The information follows:]

Department of Labor employees in the Federal Workers' Compensation Program interviewed by PSI investigators:

New York regional office: Frank Mercurio, Regional ESA Administrator; Richard Robilotti, OWCP Acting Deputy Commissioner; Anthony Campo, FEC Assistant Deputy Commissioner; John Burnett, FEC Branch of Claims Chief; Alan Gilman, ARA Assistant; Maurice Tricarico, FEC Technical Assistant, and Emanuel Noto, FEC Fiscal Officer.

Boston regional office: Walter Parker, Regional ESA Administrator; Janis Carreiro, ESA Executive Assistant; Dan Sullivan, OWCP Deputy Commissioner; Mary Andrian, OWCP Supervisory Claims Examiner; Peter Whaley, Claims Examiner, and Omar Canty, Rehabilitation Specialist.

Senator COHEN [presiding]. The subcommittee will stand adjourned for 10 minutes.

[Brief recess.]

[Members of the subcommittee present at the time of recess: Senators Cohen and Rudman.]

[Members present after the taking of a brief recess: Senators Roth and Cohen.]

Chairman ROTH [presiding]. The subcommittee will please be in order.

Senator Cohen?

Senator COHEN. Senator Rudman was in the process of questioning the witness about private-sector comparisons with insurance companies who have the responsibility of making payments for checks they might have.

Ms. HAINER. I think it boils down to a difference in attitude and approach. The private-sector people we talked with in the offices we reviewed, expressed an understanding that claims verification did not necessarily mean investigating to the point where you deny benefits. It simply meant claims validation. This could work to the benefit of the claimant in most instances to insure adequate medical treatment, to insure timely rehabilitation, to establish some sort of personal contact with the claimant, so that the communication was not always conducted through the mail.

There was an attempt to show on the part of the insurer, at least, concern for the well-being of the claimant. There were efforts, very strong efforts to use doctors and medically trained personnel to review claims. In most instances, private insurers will keep nurses on staff to review claims and medical treatment rendered, to review the information for validity, and for reasonableness of cost. At the Department of Labor, as I mentioned, we saw the completely opposite attitude, that claims should not be or could not be investigated, therefore, they would not be validated.

Senator COHEN. Let me just followup on what Senator Rudman was asking, Mr. Chairman. I think it comes down to a basic philosophical attitude as far as the Department of Labor, that of the Federal Government, versus the private insurers.

An attempt is written into most worker's compensation statutes to say you should construe the statute liberally. In other words, you should construe it in such a way as to give every benefit of the doubt to the claimant. If you can resolve the evidence in favor as opposed to resolving against—there is, I guess, at least congressional intent, I am sure legislative intent in most States to construe it favorably toward the injured worker.

What has happened, however, is that our Department of Labor has construed that particular congressional intent, as far as giving the benefit of the doubt to the worker, as being a prohibition against any sort of reasonable, or even an intensive investigation as to the nature of the service rendered, the reasonability of the service rendered, the reasonability of the charges billed to the Federal Government for that service. Furthermore, the Department of Labor has construed that there is to be under no circumstances any examination into that because of the belief that this must be construed in favor of the worker under all circumstances. Is that a fair summary of what you found?

Ms. HAINER. Definitely, Senator, and I would say it extends to giving the benefit of not just the doubt but the benefits to the medical providers, because bear in mind that in most of these cases we have illustrated here, especially those involving Dr. Josephs, the claimants were not receiving benefits after they returned to work. Money was paid directly to the doctor.

The claimants were not involved in the cases, they were not requesting anything from the Department of Labor after a certain period of time. Benefits went directly to the doctor, and it is this type of nonvalidated, just pay out attitude that we are questioning.

Senator COHEN. I think we established that the program tends to have the same doctors, same attorneys. Do you also tend to have the same druggists involved in terms of having prescriptions filled?

Is there a closed circle that we tend to have the same people involved in the treatment of these various individuals? I guess I am going beyond the obvious fraud and abuse under the current system. Is there any extension of that into kickbacks, for example?

Ms. HAINER. We saw in some of the cases we were looking at that, in Dr. Josephs' cases, the same drugstore was used all the time, but I am not in a position to say whether that was because it was one of the conveniently located drugstores in that area.

Senator COHEN. That is all I have, Mr. Chairman.

Chairman ROTH. Just one final question. As I understand the situation, the Department of Labor, which is responsible for the administration of the program, does not suffer any financial loss through overgenerous or even fraudulent payments. It is the agency or the department that hires the Federal employee who has to pay the costs of the claim; is that correct?

Ms. HAINER. That is correct.

The Department of Labor pays the benefits directly to the claimant, but at the end of the year, the Department of Labor gives an accounting to each employing agency and there is a charge back system in which the employing agency pays back the compensation fund for their employees.

Chairman ROTH. Is there any evidence that the employer, the Federal employer, the Department or agency has complained about the administration or tries to follow through in these cases or do they totally rely on the Department of Labor.

Ms. HAINER. Senator, we have talked with representatives, specifically the Inspectors General and their staffs in several different employing agencies. We hear from them that they have difficulty when they want to review the files of their own employees who have compensation claims. They usually don't, they tell us, get the cooperation they would like from the Department of Labor in making this information available to them even though it is their employee who is on compensation and it is the agency's money in the end that is going to the employee.

They have tried to, in some instances, which you will hear more about tomorrow from the panel of witnesses, they have tried to initiate projects to review their own employees who were on the long-term disability roll and the level of cooperation that they received from the Department of Labor was often inadequate.

Chairman ROTH. By inadequate, could you be a little more precise?

Ms. HAINER. It was on several occasions obstructive, where the Labor Department simply would not turn over files.

Chairman ROTH. Did the Department of Labor give you a reason for not doing so?

Mr. Cox. They claimed that the Privacy Act would preclude them from providing the agency with files of their own employees. When this excuse was offered to the agency investigators, it was the Department of Labor Inspector General who succeeded in obtaining access to the files.

Labor's own inspector general requested them to provide the files to the other agencies.

Chairman ROTH. Thank you very much.

Our next witnesses will be the panel testimony of Lois Ryan—will you please come forward—Richard Giannino and Hector Monthalvo. Would you please rise? Under the rules of the subcommittee, all witnesses must testify under oath.

Raise your right hand. Do you solemnly swear to tell the truth, the whole truth and nothing but the truth, so help you God?

Ms. RYAN. I do.

Mr. MONTHALVO. I do.

Mr. GIANNINO. I do.

Chairman ROTH. Thank you. Please be seated.

TESTIMONY OF LOIS RYAN, RICHARD GIANNINO AND HECTOR MONTHALVO

Chairman ROTH. At this time, I would like to call upon the chief counsel of the subcommittee to identify the next witnesses.

Mr. WEILAND. Mr. Chairman, this panel is comprised of three present or former Federal employees who have received Federal workers' compensation benefits. Ms. Lois Ryan works for the Internal Revenue Service. Richard Giannino is presently and has been for some time an employee of the Postal Service as a letter carrier and the third witness, Mr. Hector Monthalvo, is a former employee of the Department of the Army.

Chairman ROTH. Thank you.

Ms. Ryan, earlier today the subcommittee staff introduced evidence of your treatment by a Dr. Josephs. Can you please tell us about your injury and how you came to be treated by Dr. Josephs?

Ms. RYAN. Well, in mid-December 1978, I hurt my back at work trying to close a drawer in my desk that was not functioning properly, and I was sent home. My supervisor made out an accident report and I went to Dr. Josephs because he was my family physician and he gave me heat treatments, muscle relaxers, and pain killers that he prescribed and a shot.

Chairman ROTH. How long were you out of work?

Ms. RYAN. About a month.

Chairman ROTH. When was the last time you were treated for this injury by Dr. Josephs?

Ms. RYAN. It was in March or April 1979. I can't recall positively, because I don't have any record myself of when I stopped going to him.

Chairman ROTH. We have seen evidence that Dr. Josephs billed the Department of Labor for allegedly providing treatment to you on a twice-weekly basis during the period between December 1978 to May 1980. Your statement indicates that you stopped seeing Dr. Josephs over 1 year before he stopped billing for your visits and treatments.

The evidence before this subcommittee indicates that Dr. Josephs was paid over $2,000 for treating you over 100 times for your injury. Were you aware that Dr. Josephs was still billing the Department for these alleged visits?

Ms. RYAN. No; I was not.

Chairman ROTH. Was any attempt made by anyone in the Department of Labor or your own employer to substantiate these claims?

Ms. RYAN. No; I was never contacted by anybody.

Chairman ROTH. Ms. Ryan, the subcommittee also has evidence concerning your receipt of prescription drugs from Dr. Josephs. These bills were submitted to the Department of Labor by a pharmacy and were paid as part of your claim. The bills indicate that you received a monthly prescription for Darvocet, a controlled substance, and a muscle relaxant every month from December 1978 to August 1979.

Did you receive any of these drugs from the pharmacy?

Ms. RYAN. Only the initial prescription, and I never even finished those two bottles of prescriptions.

Chairman ROTH. Were you aware of the fact that a pharmacy billed the Department of Labor for seven renewal prescriptions during the period January through August 1979?

Ms. RYAN. No; I was not.

Chairman ROTH. Mr. Giannino——

Senator COHEN. Mr. Chairman, may I ask one question?

I think you were treated only one other time by Dr. Josephs other than a minor illness which is not connected to your work, is that right?

Ms. RYAN. Yes.

Senator COHEN. Were you ever billed by Dr. Josephs for that other treatment?

Ms. RYAN. Yes.

Senator COHEN. He did bill you?

Ms. RYAN. Yes.

Chairman ROTH. Mr. Giannino, please tell us how you were injured and how you came to be treated by Dr. Josephs?

Mr. GIANNINO. The day of the injury I was delivering my route. I was walking in the street and it had rained that day and there was mud and leaves in the street. As I was walking, my left leg slipped a little bit. With the bag on my shoulder I went off balance and fell over on my left knee.

I had to go back to my jeep and I went back to the office. There I filled out a CA–1 and called Dr. Josephs who was my family physician at the time.

Chairman ROTH. After your first visit to Dr. Josephs, what kind of treatment did you continue to receive?

Mr. GIANNINO. After the initial treatment, I went back 2 days later for a booster shot of tetanus. I had received a tetanus shot at the initial treatment. There was a booster shot of tetanus and another shot I think for the swelling in my knee, it was swollen up from the buildup of water.

Chairman ROTH. As I understand, you saw him once during the period June to December 1976 and you received X-rays on a random basis. Mr. Giannino, the subcommittee staff has reviewed your Department of Labor claim file. That file indicates that you purportedly saw Dr. Josephs on a twice-weekly basis until February 1980.

These records, which were submitted by Dr. Josephs, indicated that your leg was restitched every month for 3½ years and that you saw Dr. Josephs over 280 times. The doctor was paid over $4,000 for this treatment. Was you leg ever restitched?

Mr. GIANNINO. No; after about 3 weeks the stitches were taken out.

Chairman ROTH. So as far as you know, there was no basis for these claims?

Mr. GIANNINO. Of the restitching? No.

Chairman ROTH. Did you see Dr. Josephs on a twice-weekly basis until February 1980?

Mr. GIANNINO. No; only on a twice-weekly basis for the first few weeks.

Chairman ROTH. The medical bills submitted by Dr. Josephs and paid by the Department of Labor indicate that you received a shot every week until February 1980. During the period June 1976 to February 1977, when you were actually treated by Dr. Josephs, how many shots did you actually receive?

Mr. GIANNINO. Four or five.

Chairman ROTH. Four or five?

Mr. GIANNINO. Yes.

Chairman ROTH. Were you aware that Dr. Josephs was billing the Department of Labor for treatments of your leg for 3 years after you stopped seeing him?

Mr. GIANNINO. No.

Chairman ROTH. Did any employee of the Federal Government ever discuss this matter at any time with you?

Mr. GIANNINO. After I went back to work, I was never notified anymore.

Chairman ROTH. Never contacted?

Mr. GIANNINO. No.

Chairman ROTH. Thank you. Do you have any questions?

Senator COHEN. No.

Chairman ROTH. Mr. Monthalvo, would you please tell us how you were injured and how you came to be treated by Dr. Josephs?

Mr. MONTHALVO. In February 1978, I was working on a machine and I injured the elbow, so I went to the medical facilities. They treated me there for about a month. They couldn't do much there so they finally sent me to Public Health in Staten Island and they treated me there for about 2 months. Finally, they couldn't do anything for me. They told me they had to operate or else I have to live with the pain. So what they used to do, to describe it, they used to give me novacaine injections and it would relieve it for about 2 or 3 weeks. In my kind of work. it is kind of hard because I am a diesel mechanic on tractors.

Anyway, I started going to Dr. Josephs after they told me they couldn't do anything for me at Public Health. I went approximately twice a month and at the beginning I got a couple steady shots, injections, needles and that was it. A few times I got medication. I went to Tick Tock Pharmacy and I got pills and that was it.

Then I continued going. In the summertime it is not as bad. In the wintertime, it is a little bit more chronic. But I went on the average twice a month, that is it. The last time I went it was in April of this year.

Chairman ROTH. The subcommittee staff has reviewed the medical bills submitted by Dr. Josephs to the Department of Labor on your case. Dr. Josephs billed the Department of Labor for almost $5,000 worth of treatment. These bills indicate that Dr. Josephs commenced treating you on March 6, 1978, a few days after your injury. Is it your testimony that Dr. Josephs did not begin such treatment on that date?

Mr. MONTHALVO. He did not.

Chairman ROTH. These same medical bills indicate that you were seen 281 times by Dr. Josephs, virtually every Monday and Friday from March 1978 to April 1981 and that you received injections and had your arm strapped every visit. How often did you actually see Dr. Josephs and what sort of treatment did you receive?

Mr. MONTHALVO. All I did was get heat treatments and like I said, at the beginning I got approximately 15 injections and that was it. Mainly it was heat treatment, the lamp; that was it.

Chairman ROTH. Mr. Monthalvo, the Department of Labor file on your case indicates that in June 1979, the Department of Labor's district medical director recommended to the Department of Labor claims officials that you see a Board-certified orthopedic specialist.

Did you ever receive any communications from the Department of Labor claims officials to see another doctor?

Mr. MONTHALVO. No, Mr. Chairman, I did not.

Chairman ROTH. At no time?

Mr. MONTHALVO. No.

Chairman ROTH. Have you had any recent contact with Dr. Josephs?

Mr. MONTHALVO. In April or May, they sent me a letter to get in touch with a Dr. Healy, something like that. I did get in touch with the doctor, orthopedic doctor sponsored by the Department of Labor. When I called them up they said they never got any paperwork from the Department.

So I got a second notice within 10 days, telling me that I had *x* amount of days and this is the second notice saying to get in touch with the doctor again. This time they had a different address, so I did call again and this is when Mr. Cox just coincidentally came to my home and I told him I had just called this doctor again and the secretary told me that they had no paperwork on me. Then I gave them my name and phone and told them if they do receive any paperwork from the Department of Labor to get in touch with me. Nobody has gotten in touch with me.

Chairman ROTH. When did you first hear that Dr. Josephs had billed the Department of Labor for over 280 visits?

Mr. MONTHALVO. Excuse me, could you say that again, please?

Chairman ROTH. When did you first learn that Dr. Josephs had billed the Government for over 280 visits?

Mr. MONTHALVO. I just heard it from Mr. Cox.

Chairman ROTH. I would like to ask you a similar question. When did you first learn that Dr. Josephs had billed for over 200 claims in your case?

Mr. GIANNINO. A month ago I got a call from Mr. Cox here from the Senate saying that there was an investigation on compensation procedures. That was the first I ever heard of it.

Chairman ROTH. Senator Cohen?

Senator COHEN. Just one question, perhaps, to either Howard Cox or Karen Hainer. Again, coming back to the Tick Tock Drugstore. As I understand the testimony, the Tick Tock was submitting prescriptions for refilling to the Department of Labor. How does that work? I thought that when you have a prescription, if you are going to have it filled, you, the patient, have to go down to the local drug store, give them your prescription and they refill it as required and then they can submit the records to whomever is going to pay the bill.

How does that work in this case where Tick Tock submits a number of prescriptions to be refilled, which Mrs. Ryan never received, over and over again to the Department of Labor? How does that work?

Ms. HAINER. In the case of any medical bill, drug bill, pharmacist bill, the pharmacist or doctor bills the Department of Labor directly. The reimbursement does not, the claimant does not pay the pharmacy and then ask the Department of Labor for reimbursement.

Senator COHEN. I understand the pharmacy submits the bill to the Department of Labor. What I want to know is how does the pharmacy go about submitting prescriptions they never fill to the Department of Labor?

Ms. HAINER. Senator, I can only say that the pharmacy has complied with our request for documentation on these bills and they do have in their own files, which they have given to us by subpena, copies of the doctor's prescription that was given to them on Lois Ryan's case. I am simply not in a position to speculate.

Senator COHEN. I just wonder how this all comes about when in fact you have a doctor referring patients to a certain drug store and then the pharmacy then refills or theoretically refills prescriptions that were not in fact filled and submits them to the Department of Labor. It wasn't clear to me from the materials you had prepared.

Mr. Chairman, I think what we have seen from the two staff members and then these three witnesses here is something that, once again, we have been exploring now for several years. It is that we have a situation where it is very high-profit, there is low or practically no risk of detection and even if there is detection, there is virtually no punishment dispensed.

I guess we haven't heard yet, but I believe you, Mr. Monthalvo, called Dr. Josephs sometime in the spring and you were told what?

Mr. MONTHALVO. I was told he was on vacation.

Senator COHEN. He is doing a year's time in prison. But even a year's time, think about that. I can recall being a prosecutor and we used to put petty thieves away for a lot longer than a year's time. If you have a shoplifter, a 15-year-old boy or girl shoplifting, they used to get, on a repeater basis, pretty severe sentences in my State. Here we have a physician milking the public of thousands and thousands of dollars in the course of a year and he gets a 1-year sentence.

This is typical of all of our programs we have. It cuts across the board in terms of stealing automobiles. We had testimony 2 years ago about the high profit in the stealing of automobiles, with practically no chance of detection, and, when indicted, no prosecution, or, if prosecuted, a very light sentence.

It seems to me here is another example of the difference in treatment we have for white-collar crimes versus others. But a year's time does not seem anywhere near sufficient for the magnitude of the offense.

Chairman ROTH. Thank you, Senator Cohen. And thank you for appearing here.

At this time, I would like to call forward Morton Henig, who is the Senior Associate Director for the Human Resources Division, General Accounting Office.

Mr. Henig will present a summary of the work that the General Accounting Office has accomplished over the last few years in reviewing the Department of Labor's management of the Federal workers' compensation program.

Mr. Henig, would you please rise? Raise your right hand. Do you solemnly swear to tell the truth, the whole truth and nothing but the truth, so help you God?

Mr. HENIG. I do.

Mr. WORREL. I do.

Mr. KAUFMAN. I do.

Chairman ROTH. Mr. Henig, would you please proceed?

TESTIMONY OF MORTON E. HENIG, SENIOR ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BOBBY WORREL, ATLANTA REGIONAL OFFICE, AND HARRY KAUFMAN, GROUP DIRECTOR, DEPARTMENT OF LABOR AUDIT SITE, GENERAL ACCOUNTING OFFICE

Mr. HENIG. Mr. Chairman, I have with me two additional witnesses. On my right is Bobby Worrel from our Atlanta Regional Office, who has been involved in our work in the FECA program for the last 3 to 4 years, and Harry Kaufman, who is Group Director of the Department of Labor audit site, also responsible for that work.

I have provided a copy of my testimony to the subcommittee. That will be part of the record.[1] What I will do is try to summarize it to try and save some time.

Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss a number of GAO reports issued in the last few years on the Department of Labor's Federal employees compensation program as well as our recent followup work requested by this subcommittee.

The major problems disclosed by our reviews were, personnel and administrative inadequacies in the program had contributed to untimely, inaccurate, poorly documented, and inconsistent claims and determinations. The 1974 amendments to FECA which allowed continuation of pay without a waiting period after injury, resulted in a dramatic increase in the number of minor and trivial, frivolous claims that diverted labor's efforts from more serious claims. Federal agencies seek participation in the data-gathering, COP, monitoring, rehabilitation, and appeals process that has been limited or neglected, although the agencies must bear the costs of the program.

The act creates incentives for workers to claim and in some cases retire on compensation because its benefits structure which in some instances provides benefits higher than pre-injury take-home pay.

Labor's decisions over the years have provided an expansive interpretation of what constitutes a compensable injury under the program

[1] See p. 123 for the prepared statement of Mr. Henig.

and coupled with broad definitions and inadequate guidelines on the work-relatedness of diseases and uncertainty about the causes of many diseases have resulted in expanded program coverage.

The administration has proposed legislation which we believe will address some of the deficiencies in the program. The main purpose of our followup work was to ascertain Labor's actions with respect to our prior recommendations. Due to time constraints, we did not review a sample of recently settled disability claims to ascertain whether recent Labor actions have resulted in improved claims adjudication.

Further, because the subcommittee staff was reviewing individual medical bill payments, we did not include this area in our work.

In our past reports, we said that, one, program staffing had not kept pace with the increased FECA workload. Two, claims examiners were not adequately trained.

Three, benefits were awarded without adequate evidence. Four, policies were such that disapproved benefit claims were more stringently reviewed than approved cases.

Five, the management information system did not give management necessary information on timeliness of claims processing and, six, Labor's guidelines lacked minimal factual and medical standards for award determinations. GAO made a number of recommendations to Labor regarding the administration of the FECA program.

While Labor has initiated actions in each of these areas, we feel more has to be done by Labor.

In our 1978 report on improvements still needed in the administration of FECA, we recommend that Labor consider additional staffing requirements. In August 1978, Labor evaluated its long-range staffing need and concluded that additional staff, in fact, were needed.

To control the workload problem, the number of employees to administer the program increased from 753 in 1977 to 980 in March of 1981.

The number of full-time FECA claims examiners was increased from 319 to 367. Labor has also initiated training programs for the claims examiners.

Newly hired examiners attend a basic course which allows the claims examiners to follow a simple, traumatic and nontraumatic injury case through all phases of the process. Upon completion of the course, they should be capable of developing relatively uncomplicated cases with minimal supervision.

We find only 14 of the 367 claims examiners had not attended this course as of May 1981.

About 1 year after on-the-job experience, the examiners attend another formalized advance course which helps the claims examiner understand complex medical reports and handle more difficult cases such as occupational diseases.

Of the 367 full-time claims examiners, 55 have not attended the advanced course. In our discussions with Labor officials they indicated that formal and intensive training has resulted in significant improvements in the processing time for traumatic injury cases and the quality of case dispositions.

I will deal now with the lack of management controls.

To improve both the timeliness and the quality of claims adjudication in our 1978 report, we recommend that Labor, one, place as much emphasis on decisions to approve or continue compensation as it does on decisions to reject, terminate or reduce compensation and install a management information system that will give managers at all levels the information they need to insure that activities are being conducted in accordance with the act and established criteria.

According to Labor, the work of the claims examiner is now subjected to several reviews. First, all claims, approved as well as disapproved, are supposed to be reviewed by a second party, at least at the supervisory level.

Second, the regional and national offices conduct accountability reviews of approved cases to identify processing deficiencies and the need for closer supervisory review or additional training.

The national office accountability reviews have found significant improvement in case dispositions.

Senator COHEN. Can I inquire, what are the timeframes you are referring to on the new checks?

Mr. HENIG. These are fairly recent.

Senator COHEN. After the investigators——

Mr. HENIG. No; these are before the current investigation by the subcommittee staff.

Senator COHEN. How would that account for the subcommittee staff, almost on a random basis, picking cases involving FECA and coming up with these kinds of views? How could they possibly have been allowed to continue with these changes that have been put in place by the Department of Labor?

Mr. HENIG. I don't think I can account for the entire difference, but we were talking primarily about the adjudication of the actual claims, compensation claims, as opposed to medical payments.

The medical payment process is somewhat different.

Senator COHEN. If I may, Mr. Chairman, for the moment, we are dealing with a different issue now. What you are testifying to is more scrutiny involved in the initial award.

Mr. HENIG. Yes.

Senator COHEN. But so far the scope of this particular hearing has been devoted to what happens after the award has been made. Where is the followup, where is the check? That is what the witnesses testified about to date, that we have a system that is virtually out of control, we have no controls, we have no oversight, we have no checks.

I found, for example, listening to the witnesses, nothing that I could find in error with a man twisting his knee, or requiring a stitching of his knee. This appears totally legitimate from my own experience. A woman twists her back in the office, putting a drawer back in, and again, this is legitimate under worker's compensation. I found no difficulty with the award itself. But what has been done once an injury has been established? Once a patient is on disability, where in this whole system is there any check on it?

Mr. HENIG. Recently, the Department of Labor has done some more checking, but we are talking now—will be talking about the people on periodic rolls. These are people totally disabled who continue to be paid compensation by Labor. The cases that were discussed this

84-776 O - 81 - 5

morning are people who went off the compensation rolls, who went back to work after a period of time, and Labor was not doing a very good job of checking billings from the medical providers in those cases. Our understanding is that Labor is doing some useful things—and I will get into that a little later in my testimony—as far as following up, monitoring people who are on the periodic rolls, long-term disabled.

In our 1970 report, we also noted Labor's inability to track and manage cases and recommended the institution of a management information system which would do so. Labor has since developed automated systems to assist in program administration.

Because the systems are not actually operational, we did not evaluate their effectiveness.

Although Labor has improved its timeliness for claims processing, our current work indicates it is not yet meeting prescribed standards.

We concluded while Labor has not completed action on past recommendations plans have been initiated to alleviate some administrative and personnel inadequacies in the present program.

I would next like to get to the 1974 amendments. The FECA amendments of 1974 provided for the continuation of employee's pay after a job-related dramatic injury 45 days prior to a 3-day waiting period and subsequent compensation.

The COP provision was meant to eliminate the gap in the employee's cash flow resulting in the Labor's claims processing delays, reduce the backlog of claims, and thereby reduce Labor's processing time.

We reported in 1978 that the number of lost time injury claims filed by Federal workers escalated sharply after the amendments.

In fiscal year 1974, about 12,000 claims for job-related, lost-time injuries were filed. By fiscal year 1976, the first full year amendments were in effect, the number of such claims had risen to about 80,000 and we estimated that the COP provision was costing the Government about $45 million in that year alone.

Senator COHEN. What was the change in the law?

Mr. HENIG. Prior to the COP provision there was a 3-day waiting period before you could get on compensation. The law then said that the agency could continue to pay the individual after an injury, after 45 days, and if the injury was still such that the worker was unable to go back to work, then he would file for actual compensation under the FECA.

Furthermore, we believe as many as 45 to 46 percent of all claims might have been eliminated by instituting a 3-day waiting period before receiving COP.

During the first half of fiscal year 1981 over 80,000 injuries were reported. In the absence of legislative amendments to institute waiting periods for COP as recommended in our past report, we believe Labor will be facing an increasing number of reported injuries and costs.

Labor's proposed legislation would effectively deal with this problem.

Earlier today we talked about employing agencies needing to get into the picture a little more. We have reported on that. We say the employing agencies' participation in the Federal employees' compensation program has been neglected. Since the passage of the 1974

amendments, Federal agencies have been responsible for making COP payments to injured employees placing the agencies in a more prominent role in developing traumatic injury cases. However, we believe Labor has not provided the Federal agencies with sufficient authority to go along with their responsibilities.

Agencies cannot withhold COP without Labor's approval except in certain limited circumstances. In the June 1979 report, we recommended that the agencies be given the authority to withhold COP in controversial cases for claims that lack adequate medical evidence and when medical evidence indicates that the employee is able to return to light duty, but refuses to do so.

Again, Labor's proposed legislative package will probably address this problem.

We also have other comments about the agencies lacking an appeal right in certain cases.

Chairman ROTH. Lacking what?

Mr. HENIG. The right to appeal.

Chairman ROTH. In the interest of time, we are really not considering that particular aspect of the problem this morning. I wonder if you could just summarize anything that has direct relevance?

Mr. HENIG. I think the most important thing I would like to discuss, Mr. Chairman, is our belief that the more you involve the agencies, the employing agencies, in the process, the better the program will be operated. This morning there was some talk about the way the insurance industry that handles workers' compensation deals with problems. We believe that the employing agency, where the workers are, will be able to do a better job of accumulating evidence before a claim is filed and for monitoring people who already are on the rolls.

We made proposals in our prior reports to get the employing agencies more involved in the process. We understand Labor is in agreement with that concept now. We have a report with which we will be making recommendations to Labor and OMB.

Senator COHEN. What incentives are there in the act today to give any agency oversight incentive, or supervisory incentive? Is there any kind of penalty? We went through this when we talked about the Health Care Financing Act, all along the whole chain of the claims, the service, and the payments, that there was actually no supervision by the Federal authorities as such.

What penalty is involved for a supervisor to OK something? Should there be something that you would recommend that we reduce the budget of that department to the extent that GAO finds there has been fraudulent and abusive activities prevalent throughout that agency? And should we reduce their budget, fire people who are in charge or should be in charge of overseeing it? What incentive is there for employees to save the Government money?

Mr. HENIG. Really, there are no incentives. There is a penalty but I think there has to be—I guess the words are willful intent. I suspect that is pretty hard to prove that a supervisor would willfully withhold a claim from being filed.

Senator COHEN. We have to get back to the basic philosophical problem of the witnesses earlier, and the staff testified in going out to the regional office that Senator Rudman was inquiring about, the attitude certainly at that level is we are supposed to construe this in

favor of the worker. Therefore, we are not to investigate this or to assume any responsibility for the reasonableness of the charges, validity of the charges, or anything else. It is to be construed totally in favor of the worker. Therefore, there is no responsibility on our part. That is something I think is deeply imbedded within the Department itself. It seems to me unless we change that particular attitude or have some measure of imposing accountability to people who are supposed to be in charge, then we are going to see a continuation of the same old process.

Mr. KAUFMAN. Senator, the Government agencies that do have an incentive to see that compensation program is properly administered are the Government corporations and TVA, Postal Service, and the Government Printing Office. They have the incentive because they are supposed to be self-financing.

Therefore, these excessive compensations place an undue burden on these corporations and they are trying to work with the Department of Labor.

In the past the Department of Labor had not been very receptive to their efforts, but recently they are now working with corporations.

Senator COHEN. The point about the Postal Service being self-financing, I guess that is not the greatest example we could use.

Mr. HENIG. I agree there ought to be more incentives. I don't know how you would establish them. I think you are correct it is probably an attitudinal problem to some extent. How you cure that one, how you motivate people to be more diligent, I am not sure.

Chairman ROTH. Let me ask you a question.

We have the Office of Management and Budget, it has seemed to me that in recent years that organization has been primarily concerned with budget and not management. What would be your comment in trying to get the OMB to take a more direct interest in this kind of a problem from the oversight point of view?

Mr. HENIG. In the report that should be issued very soon, we are proposing that OMB study the feasibility of getting the employing agencies more involved, have the direct contact with the injured worker, doing more work as far as monitoring, investigating the claims.

Chairman ROTH. One of my concerns is that we keep talking about making further studies. It seems to me pretty obvious that we have a serious problem on hand. We really cannot waste another year or two trying to determine what the problem is and what should be done. It seems to me the time has come for some action. You yourself in your own testimony point out that a number of studies and recommendations have been made over the past several years. But we have seen the cost balloon 300 percent in 7 years, but no increase in employees. What can we do to get action now?

Mr. HENIG. We have made some proposals which will deal with those.

Chairman ROTH. I realize there are some problems with the law or at least there are insufficiencies. I am talking about strictly administration.

Mr. HENIG. I believe some of the things you discussed this morning, some of the weakness is in the medical payment process. Labor will have to take some action to tighten up those weaknesses.

We propose a feasibility study by OMB, because if you get the other agencies involved more than now it will cost the agencies something in the way of additional personnel, after you establish a different system.

We think it would be better to have the agencies do certain functions than have Labor people, who are situated only in the district offices of Labor, and not spread throughout the country like the agencies are, do them.

So we think that there is some merit in taking a look at it, to make sure it is the proper thing to do, to incur additional cost at the agency level to implement the program better.

We think that some of the things that Labor has done, has started to do, as a result of the recommendations we have made in several previous reports are a step in the right direction. It is a matter of how long it will take them to get from A to Z. Are they moving fast enough? We think they probably could do more, maybe move faster. We did see them taking some steps in the right direction.

We did not look at the medical payments area which the subcommittee has looked at. Obviously there is a need for considerable improvement there.

I would mention that we have looked at the same type of situation in other programs and we found what you uncovered in FECA medical payments is not unique to FECA, medicare has some similar problems.

We just finished some work in the medicare area where we found that the carriers' computer systems did not preclude duplicate payments if they were not identical billings. I am sure in the Labor computer program there is probably a procedure that if the bill is an exact duplicate of the prior bill, it will get flagged and somebody will have to check it.

Chairman ROTH. Let me ask you this kind of a question:

For example, you have a schedule of fees for medicaid and medicare. Is there any reason that those schedules couldn't be helpful in the containment of cost in this area?

Mr. HENIG. I don't believe there would be a problem. Although I am not responsible for work in the health area, I do know that their computer programs have customary and reasonable fees built in as edits, and if the fees charged exceed that amount, the computer would flag it.

Chairman ROTH. I guess the thing that concerns me is the problem raised by both Senators Cohen and Rudman, is the attitudinal problem. One, there doesn't seem to have been too much concern about the administration of the program, and on this point I always get concerned. They say, "We are studying it; we are going to do it next year." The time has come where we need action now, not further study.

Senator COHEN. I was going to suggest, Mr. Chairman, that the testimony of the witnesses now really pertains to something we don't have any jurisdiction over. We are talking about changing the law as far as workers' compensation is concerned. I assume that is to go before the Labor Committee. Much of this, whatever you say may be helpful, but frankly—the workmen's compensation program is a valuable program, just like home health care is a valuable program. What is unfortunate is the people who attach themselves to this gravy train that is moving through.

In this case it happened to be some unscrupulous physicians or pharmacists, which is another item altogether. But I don't see Congress realistically changing the thrust of the workmen's compensation program of trying to construe it in favor of the employee wherever reasonably possible.

So I don't think we ought to spend much time, frankly, focusing upon that aspect of it, as far as this subcommittee is concerned. Perhaps the Labor Committee should focus upon that aspect. But what I am concerned about is once you have a valuable program, all the employees injured on the job here seemed to me to have presented cases which automatically would be approved assuming there is medical evidence to support them, and they would be approved by any Commissioner reviewing that evidence.

The real problem is what happens in the moment they make that award. That is something that is appropriate for this subcommittee to focus upon. That is something where I don't see any kind of a supervisory role here. There is no incentive to cut down, to save money. This is true of this program, and the programs that Senator Nunn was investigating in the past. There simply are no incentives on the part of the Federal establishment to oversee how they are spending the taxpayers' money.

I haven't heard that part of the recommendation you will make in terms of what can we do to focus on that and institute management systems. But, Mr. Chairman, I do not see any purpose in our reviewing the purpose of the law, but rather how might we tighten up, how might we insist upon more or better assessments of medical cases.

You always have the problem of detection of a malingerer, those filing false claims, I don't see that as the nature of the problem here, to suggest a change in the law with a dramatic increase in claims. That is something we cannot deal with. But we can, I think, insist upon some recommendations coming from the Department of Labor or perhaps through OMB or GAO to set up some sort of system that will check this kind of system that is out of control.

There simply is not a single control that I can see here. Let the record indicate that the witness is——

Mr. HENIG. I was going to say I agree there needs to be improved controls. I indicated earlier I think Labor is taking some action to improve their own management of the program.

We think that that will be helpful.

Senator COHEN. I would like to hear the specifics when the Department of Labor comes forward.

Thank you, Mr. Chairman.

Chairman ROTH. Senator Nunn?

Senator NUNN. Just a couple of questions, Mr. Chairman.

Does the Department of Labor have an active program of detecting fraud in this area?

Mr. HENIG. They had a pilot project in Atlanta where they got together with seven other Federal agencies and went back over a number of the people on the periodic rolls. They did find a number who should not have been either compensated to begin with or should not be any longer on the rolls. That has been a fairly successful project.

In my testimony, we do indicate that we think that is the kind of thing that should be continued, working with the employing agencies periodically reviewing those people on the rolls to make sure they are still valid claimants.

Senator NUNN. How about the other side of the problem, false claims being submitted not by the Federal worker, but by the physician.

or pharmacist? Do they have an active program in that regard to detect fraud?

Mr. HENIG. I can't speak to that. We did not do any work in the past or in the current followup work. But from what the subcommittee staff indicated, there probably is some need for better management on Labor's part there.

Senator NUNN. How do they go about selecting the physicians? Do they have a qualified list of physicians?

Mr. HENIG. My understanding is any qualified physician. The employee, injured employee, can go to any qualified physician for a medical report.

Senator NUNN. Should that list be narrowed? Should there be some kind of qualified physician list by the Department of Labor or is there enough abuse to warrant that kind of change?

Mr. HENIG. I cannot answer that question, Senator. I don't know whether the cases of abuse are enough that you would want to change your method of allowing the employee to select the physician or not.

In one of our earlier reports we did point out that employee selection of a doctor does result in a problem for Labor. We felt Labor ought to have their own physicians who could be called into the picture to corroborate the medical reports.

Senator NUNN. Does the Inspector General get involved in this?

Mr. HENIG. The Inspector General has done some work in the last few years in this area. They have been reasonably successful in getting some claims turned over to Justice, and some prosecutions and I believe some convictions.

Senator NUNN. So they do get involved?

Mr. HENIG. Yes; they do.

Senator NUNN. Thank you, Mr. Chairman.

Chairman ROTH. Thank you.

I believe that is all the questions.

Thank you very much, gentlemen.

Chairman ROTH. Our final witness will be Mr. McBride, who is the Inspector General, U.S. Department of Labor.

Mr. McBride, would you please rise?

Raise your right hand. Do you solemnly swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Mr. MCBRIDE. I do.

TESTIMONY OF THOMAS McBRIDE, INSPECTOR GENERAL, U.S. DEPARTMENT OF LABOR

Chairman ROTH. Please be seated.

You may either read your statement or summarize.

Mr. MCBRIDE. With the Chair's permission, I would like to ask that my statement be inserted in the record.[1]

I will sumarize it briefly.

Chairman ROTH. Without objection.

Mr. MCBRIDE. I should note I was confirmed as Inspector General at Department of Labor last Friday and from today's testimony it is clear I have my work cut out for me. I did some reviews of Department of Labor programs over the last month while awaiting confirmation. One of my major concerns was that there had been in-

[1] See p. 130 for the statement of Mr. McBride.

sufficient attention to fraud and waste problems in the programs of the office of workers' compensation.

I think it is important to note that includes not only FECA, but Black Lung and Longshoremen and Harbor Workers Act programs, which have similar problems, in the case of black lung, perhaps even a more aggravated one.

I talked to Secretary Donovan about that, how we could shift additional audit and investigation resources away from the traditional emphasis on CETA and into these other areas. He promised his full support. We also identified, in my discussions with him and with Deputy Undersecretary Collyer who runs these programs, the attitudinal problem which the subcommittee addressed this morning; that is, the attitude of "get the money out" at the expense of internal controls, review, monitoring, and safeguarding the public funds.

That has been an endemic problem. In reviewing the limited work that the Office of Inspector General has done in the FECA program, it is concentrated mainly in three areas, one, the basic internal controls, how do they make sure the claim is valid, the bills submitted are valid, that there aren't duplicate payments? They also focused on the benefit claims process; that is, are there people on the rolls drawing monthly payments, often for long periods of time, who are either not eligible because they have no injury or have recovered, or they have other employment, clandestine employment, if you will, and are receiving income from other sources while still remaining on Federal compensation rolls? Finally, we have reviewed bill payment operations which gets close to the concern of the subcommittee this morning, the medical bill payment process. We have been through seven district offices and actually gotten down to the nitty-gritty of how they pay these bills. Finally, of course, we have conducted a number of criminal investigations, most of them involving claimant fraud, but a few into medical fraud.

Over the last 2½ years, we worked about 280 cases, had 49 indictments, 23 convictions, and have about 150 cases pending. Some of those have come from referral from the office of workers' compensation programs, probably about half of that number, very few notably have been medical provider fraud allegations—only a handful. Most are allegations of claimant fraud.

We have had some recent successes in the criminal investigation area, mainly by building cooperative relationships with the other agencies, other Inspector General operations, the Postal Inspection Service, and so forth. We have about 130 cases out of the recent Atlanta project, which are under investigation now for submission to the U.S. attorney's offices in the various districts around the country and we will be expanding that project.

One of the principal concerns that I have had as we went through this work was how can we, short of actually reviewing every piece of paper, and every claim, or short of sending out field investigators to do every case, how can we isolate the vulnerable cases? How do we isolate the medical providers who may have gotten $50,000, $150,000 or $200,000 in billings. How do we isolate the claimants who appear to be the fraud risks in the total claimant population? We tested a methodology in the Atlanta project, and we will be expanding trying it nationally. We can pick out the people who have a certain kind of

injury, allegedly, the right age group, the right length on the disability rolls—a profile, if you will, of the risk-prone individual and then pull that file out of the computer systems, and match that against reported wage data from other employment. In the Atlanta project, for example, we reviewed, 1,800 cases. Out of that we found about 800 where we had some clear and serious deficiency in terms of PECA's handling of the case and 130 which hold the potential for criminal prosecution.

That is especially important when your realize that a person on the periodic roll may stay on the roll for years and the lifetime costs can be $2, $3 or $400,000. So you are dealing in major dollar fraud waste issues aside from the criminal conviction deterrent impact.

The problem, however, is how do you apply that same methodology to the medical provider? We have been, as has the subcommittee staff, frustrated. The ADP systems are quite inadequate. They have been in the design stage, if you will, for years, and the ability fully to use data base analysis is still years off. We cannot get an answer to the question, how many doctors were paid over $100,000? We just can't get it.

You can say we can look at the files, claims folders. We tried that. What we found is that they were batch-filing the bills. If you go to the claimant's file, you still don't get the doctor billings. We had the problem of identifying what is called the employer identification number when you have multiple numbers. IRS has refused to give us a list of the companion numbers. So the doctor who is practicing privately, in a partnership, in a corporation, in a clinic, with a hospital, can have 5 EIN's and we cannot access the data through that. Even if we had the EIN's, the ADP systems do not permit that access.

We have made many recommendations. Most of them tend to be pretty nitty-gritty, install standard medical fee levels, for example. We have been told that that is not presently practicable but that the ADP system will be programed to have those edits in it and that should be in effect by 1984, which to us does not seem an adequate response to what is clearly a cost control problem and a fraud control problem right today.

We have recommended that at least a sample review of medical bill payments be conducted. We are told that that has been implemented, but until we have actually verified it in the field, I would not express an opinion as to whether that is actually in effect or not.

If in effect, it obviously did not catch the instances which have been described in the testimony here today.

I mentioned the problem of filing the paid bills in batches. It makes retrieval for investigative or fraud detection purposes almost impossible. Little things in the system, such as the use of photocopy bills, are invitations to duplicate payments, either to the provider or fraudulent duplicate payments to persons working inside the system who generate bills, mail them to an address, and cash the checks.

We had a case like that of a FECA worker here in the District who embezzled $50,000 by a very simple scheme. What disturbed me about it is that the caseworker had been on the job less than a month. You think how vulnerable the system must be if, in less than a month, you can learn how to penetrate it, generate $50,000 and not get caught. This person would probably never have been caught, had it not been for

the alertness of a bank clerk, because the FECA employee made the mistake of sending all the checks to one account. Seven, ten, and twenty checks a month coming in from the Department of Labor to one account must have obviously raised eyebrows.

Other simple things, for example, medical bills are not verified. If Dr. Josephs', or the other doctors whose activities have been described here today, had their bills been routinely sent, even on a sample basis, to Ms. Ryan or the other claimants, this fraud would have been discovered long ago. That is not done; either routinely or on a sampling basis.

Doctor's forms and claims data, for example, are often hand carried by the claimant from the doctor's office to the FECA office allowing the opportunity for alteration and other shenanigans.

The overall problem of cost control is much larger than the medical provider cost.

The administration, Secretary Donovan, and Mr. Collyer's legislative suggestions while not before this subcommittee, will be very, very important because they reduce the financial incentive to stay on the rolls. If those can be reduced, there will be immense cost savings.

In the area of my particular concern, which is the fraud-waste cost savings, one, we need systems for verification of outside employment. So we know people are not illegally double-dipping. That is the purpose of our matching efforts and it is important that those be installed as part of routine FECA procedures.

Second, the medical fee schedule is very important.

Third, as GAO touched on, the employing agency has a big role to play here. Part of the problem I would suggest is, having been Inspector General in another agency, I have some perspective on this, that the employing agencies are unaware that there is a large disability caseload and a large disability item in their budget and a large potential for disability abuse. It is an area removed from the management accountability. I used to be Inspector General at the Department of Agriculture, and I didn't even know about FECA costs. That is because it is an automatic program, separate line item independently appropriated. There is no accountability. If it came out of my budget, if I had 20 or 30 people on the disability rolls whose cost I had to eat out of my budget, I would pay more attention. I think that is a fundamental incentive that is necessary in changing the budgetary framework.

Continuing, the ADP systems are a big problem. It is almost impossible to hurry up an ADP system, and yet it is ultimately the key to any effective system of internal controls in this and many other programs.

[At this point, Senators Cohen and Nunn withdrew from the hearing room.]

Mr. McBride. Usually the systems are late. The governmental procurement process causes delays. Design staffs are often not as competent as they should be. The Government is not competitive with the private sector.

Contractors do not understand Government needs. The systems, once they are allegedly working, tend to have so many flaws that the field staff become skeptical and cynical about their effectiveness. I have found that with the FECA systems. I visited some field offices. I found that they think the computer system is a joke. They put a lot of stuff in it, get nothing out. It is promises, promises.

That is something really that is a serious problem throughout Government. Internally I will be working with the program administrators. You need a very good design staff, programers, and managers to really make the thing work.

I would not express more judgments on that until I have been at Labor a little longer, but it is not going to be solved next month or next year, but I hope it will be in the not too distant future. We should build in computer controls so we are not talking about thousands of claims clerks. We are talking about using the technology which is available to us in terms of the processing these bill payments, editing out duplicates, editing out high amounts, doing all sorts of things, automated mailings to the claimants, and so forth, which are now being done manually.

The Department authority is essential, and I agreed with the testimony earlier today that that can be done by change in departmental regulations. There is no magic to that. It is a question of will. All of this, I think, gets back to the basic attitudinal problem that there is not a strong antifraud waste posture by the employees of FECA, OWCP. Indeed, it is a concern of mine with the Department as a whole. It is not seen as an overriding priority and combating that attitude is a primary concern of myself and Secretary Donovan. We will be working very hard in the months ahead to begin to turn around the minds and the management attitudes of those of this program and others.

If you have any questions, Mr. Chairman.

Chairman Roth. Thank you, Mr. McBride, I agree with you that I think the problem is largely attitudinal. I think the Government agencies have had very little incentive to be concerned about cost-effectiveness.

I agree with Senator Cohen when he says that in trying to be more efficient, we also want to keep in mind the purpose of the program and insure those who are injured and have bona fide claims receive what is their just due. But I am very concerned as we begin to look in a number of these areas, that there seems to be no will, no real interest in trying to avoid what I call almost an open invitation to defraud the Government. There are always people both within and without Government who, if they see an opportunity to exploit the system, will do so. I just feel that we have no systematic controls here, so I am pleased to hear you testify as to what you intend to do. I would like to underscore what I said earlier. The purpose of these hearings is not to have a one-shot look at these programs, but we intend to follow through on a periodic basis to insure that corrective action is being taken.

I don't expect any miracle, but at the same time, I do get concerned when some of the people testify, like on the implementation of a fee schedule that may be in place by 1984, that something can be done much sooner. I suspect they may also think that by that time we will either be gone or the matter has been forgotten. But we intend to make a special purpose of this committee and subcommittee the assurance that the programs are efficiently administered because in the long run, that is in the best interests of the beneficiaries of the program itself.

I was glad to hear you say the agency or the Department itself can do something about debarring. To me that sort of characterizes the negative thinking that has taken place too long. Frankly, if the present

supervisors of the programs cannot do the job, then I think it is about time to get those that can.

Do you see any reason in the case of debarment, not only to debar a doctor in the immediate program, but from other similar programs? If the doctor has defrauded under one Government program, why shouldn't he be debarred from providing services under all programs?

Mr. McBride. I agree, and I think that can be done. There are some models, for example, in the lending program of SBA and others where there is mutuality of debarment. It seems to me in the programs which provide medical services and those include HHS, Labor, VA, and DOD, most significantly, that some system of unified disqualification or debarment could be generated.

In the immediate term, simply information sharing is a critical need. The FECA offices—I have a list here of the medicaid debarred people. FECA district offices don't have that, nor do they have the liaison with State workers' compensation boards. And then not having the perception that they have the authority themselves to take that action, that means really there are no sanctions, no exclusions.

Chairman Roth. Going back to fee schedules, is there any reason why this program cannot adopt a fee schedule similar to those used under these other Government programs?

Mr. McBride. I see no reason that they cannot. Apparently, my staff do not because they recommended that they adopt them.

Chairman Roth. You have anticipated most of my questions.

I am glad to hear you say there is a glaring deficiency that apparently at no time has the Department of Labor contacted the Federal employees to determine whether or not they are receiving such care.

Mr. McBride, I agree with you, as you said in your opening statement, you have your work cut out for you.

I want to say that I am an enthusiastic supporter of the Inspector General concept.

I want to assure you that this subcommittee wants to be helpful and supportive in the efforts of the IG and others to make these remedies.

In closing, just let me say that after a reasonable period of time, I want to invite you and others to come back and to testify as to what progress is being made.

Mr. McBride. You will have my full cooperation both then and in the period between now and then.

Chairman Roth. There are a couple of things I would like to point out for the record before the subcommittee recesses. If the record was not clear from Ms. Hainer's testimony, we want to say that we have no evidence of wrongdoing on the part of the New York pharmacy, Tick Tock Drug. We will, however, look at the broad question of billing for drugs further.

I would also want to point out that we have just received a letter [1] from the attorney for Dr. Josephs which indicates Dr. Josephs would be willing to testify if granted immunity. We will take this under advisement. It will also be pointed out that his attorney states that Dr. Josephs denies any wrongdoing in the FECA program.

The subcommittee is in recess subject to call of the Chair.

[Whereupon, at 12:45 p.m., the subcommittee adjourned to the call of the Chair.]

[1] The letter referred to appears on p. 230.

FEDERAL WORKERS' COMPENSATION FRAUD AND ABUSE

THURSDAY, JULY 23, 1981

U.S. Senate,
Permanent Subcommittee on Investigations
of the Committee on Governmental Affairs,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to recess, in room 3302, Dirksen Senate Office Building, under authority of Senate Resolution 361, dated March 5, 1980, Hon. William V. Roth, Jr. (chairman of the subcommittee) presiding.

Members of the subcommittee present: Senator William V. Roth, Jr., Republican, Delaware; Senator Warren Rudman, Republican, New Hampshire; and Senator William S. Cohen, Republican, Maine.

Members of the professional staff present: S. Cass Weiland, chief counsel; Kathy Bidden, chief clerk; Marty Steinberg, chief counsel, minority; Howard Cox, staff counsel; and Karen Hainer, staff investigator.

[Members present at convening of hearing: Senators Roth and Rudman.]

Chairman Roth. The subcommittee will please be in order.

At yesterday's hearing, this subcommittee received substantial evidence of how medical service providers who had been indicted or convicted of medical claims fraud continued to submit claims to the Federal Government for medical services. In some instances, those providers who were caught, tried, and convicted of defrauding Federal or State medical programs, were seen to have continued to defraud the Federal Government on workers' compensation claims.

We heard additional testimony from the Department of Labor Inspector General's Office and the General Accounting Office as to their repeated warnings to Department of Labor program managers concerning the failings of the Department of Labor's management of the program.

Today we will commence our hearing with a panel of law enforcement witnesses who will describe their criminal and administrative investigations of fraud and abuse in the workers' compensation program. Later we will receive testimony from the Department of Labor officials who are responsible for the management of the program.

Our panel will consist of Mr. Charles P. Nelson of the Postal Inspection Service: Mr. James E. Bradburn of the U.S. Air Force, Office of Special Investigations, and Mr. Morris B. Silverstein, Deputy Inspector General of the Veterans' Administration.

Gentlemen, thank you for being here today.

Under our rules, you must each be sworn in, so I would ask you to please rise and raise your right hand.

I would ask all who may testify to please do so.

Do you solemnly swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Mr. NELSON. I do.

Mr. BRADBURN. I do.

Mr. SILVERSTEIN. I do.

Mr. DAVIS. I do.

Mr. MINOR. I do.

Chairman ROTH. Thank you, please be seated.

Gentlemen, I know you have prepared statements which will be included in the record as if read in its entirety and placed in the Appendix.[1]

But I would ask that each of you summarize your remarks in 5 to 10 minutes.

Mr. Nelson, if you would please begin.

TESTIMONY OF CHARLES P. NELSON, ASSISTANT CHIEF POSTAL INSPECTOR, SECURITY, U.S. POSTAL SERVICE; RONALD MINOR, POSTAL INSPECTOR; JAMES E. BRADBURN,[1] OFFICE OF SPECIAL INVESTIGATIONS, U.S. AIR FORCE; MORRIS B. SILVERSTEIN,[2] DEPUTY INSPECTOR GENERAL, VETERANS' ADMINISTRATION; AND ALBERT H. DAVIS, ACTING DIRECTOR, OFFICE OF INSPECTOR GENERAL, ATLANTA FIELD OFFICE, VETERANS' ADMINISTRATION

Mr. NELSON. Thank you and good morning.

I am Charles Nelson, the Assistant Chief Postal Inspector for security.

Seated beside me is Postal Inspector Ronald Minor. He oversees our FECA Criminal Investigative effort. We appreciate the opportunity to describe the efforts being made by the Postal Inspection Service to combat abuses of the Federal Employee Compensation Act.

Workers' compensation abuse has become a matter of substantial concern for the Inspection Service. Until the past few years, we became involved primarily when aggravated cases caused service disruptions or received publicity.

Rapidly escalating costs of the program, and the unfavorable impact on service efficiency and postal rates, have now given this area new priority. Compensation costs escalated from $46.8 million in fiscal year 1973 to $229 million in fiscal year 1979. These huge increases were triggered by the 1974 amendments to the Federal Employees' Compensation Act, which established continuation of pay, generally liberalized the program, and brought widespread publicity to the easy accessibility of compensation payments. We have also had reason to believe that costs were higher than necessary because of the program abuses and inadequate management of the program.

In order to exercise greater internal administrative control of its workers' compensation liability, postal management established the new employee position of injury compensation specialist in 1979 at a number of key post offices throughout the postal system. An increased awareness of problems and abuses identified by these specialists, at first, caused a gradual increase in the number of cases being referred to in-

[1] See p. 134 for the prepared statement of Mr. Bradburn.
[2] See p. 137 for the prepared statement of Mr. Silverstein.

spectors for investigative attention. We responded by initiating a more concerted effort to deal with workers' compensation abuse by postal employees.

General investigative instructions were written and provided to inspectors. Near the end of 1979, however, the injury compensation specialists began referring many more cases. The increased workload dictated the need for criteria to guide injury compensation specialists and postal inspectors as to the types of cases which should be investigated.

Increasing Postal Service-wide attention in matters relating to workers' compensation elevated our program to high-priority investigative status early in 1980. Program goals were developed concerning the reduction of compensation costs, the removal of offenders from Postal Service rolls and, in appropriate instances, criminal prosecution of persons involved in the submission of fraudulent claims.

Guidelines were developed for use by inspectors investigating cases of abuse. We designated a minimum of one full-time workers' compensation investigative specialist inspector in each of 17 geographical areas. In some areas, more than one specialist was designated and the specialist inspectors were provided additional people, as necessary, to assist in their investigations.

A more formal injury compensation investigation program (ICIP) was furnished to the investigative level during May 1980 and was fully implemented by the close of 1980. The program is a coordinated approach to the investigation of fraudulent workers' compensation claims. It provides for a nationally uniform application of guidelines for the administration, detection, investigation, prosecution, and reporting of workers' compensation abuse cases.

As previously mentioned, our primary objectives are reduction of Postal Service costs resulting from fraudulent claims and the removal and prosecution of employees who abuse the program. In order to make the most effective use of investigative resources, we have concentrated our attention on those cases most likely to result in administrative or prosecutive action. After a case is referred to us for investigation, it is carefully reviewed to determine if grounds are present for detailed investigative attention.

When investigation discloses evidence of a fraudulent claim, an investigative report is supplied to Postal Service management, the U.S. Attorney, and the Department of Labor for consideration of administrative and prosecutive action. Inspectors maintain an overt posture in the conduct of these investigations, and we feel the publicity has a significant effect on the attitudes of potential abusers of the FECA provisions.

During fiscal year 1980, postal injury compensation units referred 615 cases to us for consideration. Of that number, 326 cases were given further attention. The investigations resulted in seven arrests of postal offenders. Forty-five employees were removed from postal employment for filing fraudulent claims. As a result of these investigations, workers' compensation payments, which had amounted to nearly $2 million in total payments, were terminated.

Statistics gathered through quarter II of fiscal year 1981, when compared against the corresponding period last year, show an increase of activity: 183 cases were initiated through quarter II, 1981, as opposed to 166 during the same period last year. Inspectors made 10

arrests in the first half of 1981, as opposed to seven in all of 1980. So far, in this fiscal year, 49 postal employees have been removed for violating the laws on compensation.

To date, our program has focused primarily on fraudulent claims by employees. Where our investigative efforts also disclosed possible involvement of medical service providers, we have conducted investigations into the activities of the doctor or institution. These investigations comprise a very small percentage of our investigative efforts. Prior to January 1981, our program did not stress development of information on doctors.

Since then, we have amended the program and now require the analysis of claims filed in order to identify doctors known to be submitting an unusual number of claims. We currently have medical service providers under investigation, and expect that in the future, a much larger percentage of our time will be devoted in this area.

We recently completed initial evaluation of our participation in the Department of Labor Inspector General's Atlanta FECA project for the identification of fraudulent workers' compensation claims. This project included a review of selected claim files bearing on Federal employees in seven Southern States. During our review, we developed information which allowed four postal employees to be suspended and one to be terminated from the workers' compensation rolls. We were also able to refer one claimant to a rehabilitation program. The suspensions and terminations amounted to an annual savings of $60,000.

Thirty-seven additional cases were referred to specialist inspectors for further investigation. We anticipate an annual savings of nearly $1 million will accrue from the review. Because of the readily apparent benefits, we have agreed with the Inspector General, Department of Labor, to participate in a nationwide expansion of that project.

As we have gained experience with our workers' compensation investigative program, we have attempted to identify areas where the program could be strengthened. To date, we see two major areas which are in need of improvement. First, we have experienced a great deal of hesitancy on behalf of U.S. attorneys to accept this type of case for prosecution.

I am advised by field inspectors that U.S. attorneys generally believe that these cases lack jury appeal. A second area of concern is liaison with the Department of Labor regional workers' compensation offices. We are not normally given access to the claim files without first going through the Inspector General's office. This practice has often caused delays, because Department of Labor special agents cannot always be readily available to assist in this type of review.

We feel we have gotten a good start in dealing with the problems associated with fraudulent workers' compensation claims. To reinforce the program, we recently completed a series of training seminars designed to raise the proficiency level of specialist inspectors. Over 85 inspectors have participated in the training sessions. Our people now possess an in-depth knowledge of workers' compensation laws which we believe is second to none in the law enforcement field. Their base of experience will provide us with a large measure of success in the coming years.

The public has a right to expect that tax and postage dollars will not be lost to fraudulent claims. We will do our best to protect the public

interest in paying for workers' compensation only for those entitled to receive it.

Thank you.

Chairman ROTH. Thank you.

Next we will call on Mr. Bradburn.

Mr. BRADBURN. I am James Bradburn, a staff officer assigned to the contracts and false claims branch, Directorate of Fraud Investigations, Headquarters, Air Force Office of Special Investigations.

In an effort to curb the costs of the Federal Employees' Compensation Act to the Department of the Air Force, AFOSI has been actively involved in the detection and/or investigation of fraud, waste and abuse in connection with FECA. We have developed, on our own initiative, a very comprehensive investigative program.

This program has been very effective in terms of identifying irregularities, both criminal and administrative and causing a reduction in expenditures of Air Force funds.

To identify past and present Department of the Air Force civilian employees who are suspected of fraudulently receiving FECA benefits, OSI has employed a technique referred to within OSI as a fraud investigative survey. A fraud investigative survey provides our agents with a step-by-step approach which, when followed, can lead to the detection of fraud or crime-conducive program weaknesses.

We developed the individual survey outline—that is, the step-by-step approach—which our agents are currently utilizing for FECA investigations, from research and our past experience with FECA abuse.

The outline specifically addresses fraud in the following areas: Undisclosed earnings; claims filed based on a faked injury of false medical data collusion between the doctor and patient; compensation gained for injuries not job-related; failure of claimants to refund to the United States its share of moneys paid to the claimant by a third party, for example, an insurance company, as a result of a liability arising from an injury for which the claimant has received FECA benefits; failure of claimants to report changes in dependent status: and submission of multiple claims for the same injury.

Fundamental to the success of our survey methodology is the necessity of gaining access to files maintained by OWCP. These files are often the only complete files in existence and, when carefully reviewed, serve as the basis for surfacing fraud indicators or administrative irregularities.

The Office of the Inspector General, Department of Labor has provided invaluable assistance by gaining OSI access to the OWCP files when other avenues failed to gain such access.

To date, OSI has concentrated its efforts in employing the survey approach at Air Force Logistics Command installations. Air Force Logistics Command installations are essentially industrial complexes which employ large numbers of civilians engaged in manual labor and as a consequence these individuals are most susceptible to injury.

Our surveys have identified numerous claims suspected of being fraudulent, primarily in the areas of undisclosed earnings and non-job-related injuries.

We also found many administrative irregularities which requires action by either OWCP or the installation civilian personnel office. These irregularities include work tolerance exams having been com-

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pleted, but no action taken by OWCP to assign a rating as to what type or types of employment the claimant is capable of performing; failure to request work tolerance letters from physicians to determine if a claimant can return to work; failure to offer the claimant employment, even though such action had been approved by a physician; lack of followup concerning unanswered requests for work tolerance letters; lack of current physicians' reports; need for an impartial physician's opinion due to conflicting opinions with regard to extent of claimant's disability; need for current medical examination due to incomplete previous exams and reports by physicians that, contrary to the contention of the claimant, the current injury was not a recurrence of a previous injury and, therefore, not an allowable claim.

Our survey at the San Antonio Air Logistics Center resulted in two claimants being considered for prosecution, 31 claimants being removed from Department of Labor compensation rolls, and an annual savings to the Air Force of over $400,000 in terminated or reduced payments. Also, although we have been informed of action pertaining to only 14 of the 50 files regarding which discrepancies were identified during the joint Atlanta project, those actions have resulted in an annual savings of almost $75,000.

At this point, Mr. Chairman, I would like to briefly list some examples of the types of abuses we have discovered in our inquiries. The first is somewhat different than the normal administrative or criminal irregularities we have found.

It involves an individual who suffered a back injury in 1962. He was convicted of bank robbery in 1970 and incarcerated shortly thereafter. However, he has continued to receive compensation from that time.

We inquired with the OWCP claims examiners concerning the appropriateness of this. However, the examiners were unable to give us an answer. We are currently following up with the Department of Labor OIG regarding this matter.

Another abuse we have noted concerns improper doctor switching. One claimant, for example, changed physicians five times, each time without OWCP approval and after each physician had reported the claimant could return to work. Nevertheless, OWCP has continued to pay the medical bills submitted by the claimant.

Another individual, whose request for OWCP permission to change physicians was denied, changed physicians anyway, and OWCP continued to pay the medical bills. This claimant also admitted to our agents that, during the time she was on compensation, she applied for, and received, welfare funds.

State welfare officials have been informed of this and plan to pursue it once we finish our inquiry.

An example of a third party problem we noted concerns a claimant who was struck by an automobile upon leaving work. He sued the third party and collected a $100,000 settlement, but failed to notify OWCP. After this was discovered by OSI, from a review of the claim file, OWCP informed the claimant, in writing, that he should provide them with the details of the settlement. He instructed OWCP to write to his attorney. They wrote to his attorney who advised that he no longer represented the individual. The file did not reflect any further followup and, to date, the individual has collected in excess of $63,000 in compensation alone.

Another third party situation involves a claimant who, in November 1979, was injured on a temporary bridge erected on the installation by a contractor. The claim file contained a letter to OWCP from the claimant, dated February 1970, in which he stated he intended to file suit against the third party—i.e., the contractor—and had retained an attorney for that purpose. And, again, no further followup action appears in the OWCP file. The claimant has to date received $244,317 in compensation payments, as well as $10,547 in medical benefits.

A third and last example of this type of problem concerns a claimant who, sometime after suffering a work-related injury, was involved in a non-job-related automobile accident. She susbequently submitted numerous medical bills related to the accident which were paid by OWCP.

She also submitted a bill totaling $5,000 for a hysterectomy, which OWCP paid. When interviewed by OSI agents, the claimant advised she had been offered an opportunity to enter into a rehabilitation program. She stated she did not choose to do so because, if she did, she would lose her compensation benefits. No such program has been offered since.

A final example of suspected abuses we are pursuing concerns information that a medical facility has submitted billings to OWCP for treatment of injuries which the claimants contend are not work related. Although these claimants insist they advised the physicians that their injuries were not job related, the facility has submitted bills to OWCP for the injuries and has been reimbursed. One such bill for open heart surgery totaled $12,000.

Not all our surveys have been completed, several of our investigations are still ongoing and many actions by OWCP remain to be taken as a result of OSI findings.

Therefore, it is impossible for me to accurately project the total monetary savings accruing from either OSI's unilateral efforts or the joint effort involving the Office of the Inspector General. Nevertheless, from the results we have received thus far, I believe OSI's time has been well spent in this area, not only from the standpoint of the monetary savings which will accrue but from the crime deterrent effect attributed to OSI's highly visible commitment to detect fraud, waste and abuse in connection with FECA.

We have been requested by the Office of the Inspector General to participate in a new joint survey which will encompass the remainder of the United States. Depending on the scope and results of that project, we will consider initiating surveys in additional major commands at a later date. At that time, we will brief appropriate commanders to determine their desires for surveys. In an attempt to sensitize all of OSI agents to the importance of fraud in this area, and familiarize the agents with the claim filing process, its susceptibility to fraud and methods of detecting attempts to defraud the program, copies of our workers' compensation survey outline have been distributed to all OSI regional offices.

I greatly appreciate having had the opportunity to address this distinguished subcommittee on an issue regarding which the Inspector General of the Air Force shares your concern.

Chairman ROTH. Mr. Silverstein?

Mr. SILVERSTEIN. Mr. Chairman and members of the subcommittee, my name is Morris Silverstein, Deputy Inspector General of the Veterans' Administration.

I am pleased to be with you today to discuss the Veterans' Administration Inspector General's participation with the Department of Labor Inspector General's Southeastern Office's review of the FECA program.

I have with me today Mr. Al Davis, who is a field investigator for the VA's IG Office.

Mr. Davis had previously been with the Department of Labor IG's Office and has had some experience in the program.

[At this point Senator Cohen entered the hearing room.]

Mr. SILVERSTEIN. The costs incurred by the VA for unemployment compensation payments to their employees and former VA employees under the FECA Act were $32½ million in 1978, more than $38½ million in fiscal year 1979, and approximately $42½ million in fiscal year 1980.

We were initially approached in mid-1980 by representatives of the Department of Labor Inspector General's Staff to participate in a pilot project in the eight-State Atlanta region to identify recipients of fraudulent benefits under the FECA Act. We began our field work in the Atlanta region in November 1980. The selection criteria used to pursue the cases were as follows: The total compensation for the year for the individuals filed being reviewed had to have exceeded $6,000; the injury was not fatal; the period of compensation was 2 years or greater; there had been no loss of wage-earning capacity and the claimant's age at the date of injury had to be 55 or less.

Using these criteria, we selected 173 VA claimants in the 8-State Atlanta region. In addition, we obtained employment information for comparison purposes from State unemployment agencies and from a private credit corporation for a small number of employees.

Of the 173 files selected, 164 were available for review. Of these, 7 cases contained possible indicators of fraud. However, subsequent investigation by Mr. Davis indicated that there was no evidence of fraud in these cases on the part of the claimants or on the part of the medical service providers. We reviewed the remaining 164 cases for administrative shortcomings. Eighty of the 164 cases did not disclose any information indicating failure to report employment or discrepancies requiring action by the Office of Workers' Compensation.

We were disturbed to find, however, that of the 164 files available for review, 77 contained information indicating possible administrative shortcomings on the part of the Department of Labor which allowed questionable payments to be made to VA claimants.

Some examples of these are as follows: No action was taken when a claimant failed to respond to requests for information. Second, there was failure to require timely medical evaluations when it was deemed appropriate.

Third, no action was taken to resolve significant conflicting information contained in the files.

Fourth, no action was taken when medical information in the files suggested that the claimants could work. No action was taken to verify claimed dependents when that information was questionable.

There was failure to take action on cases which indicated medical treatment payments were for problems unrelated to the job injury and, lastly, no action was taken when there were indicators of excessive medical treatment.

One interesting case involved an attorney who had been receiving FECA payments since 1972. This claimant received his law degree in 1975 under the FECA vocational training program. He operated two separate law firms during much of the period that he was receiving FECA payments. He was also a special counsel for a congressional committee part of this time who received an annual salary of $34,500 for the period October 1976 through mid-April 1977.

By reporting much of his income in relation to the law firm as a bonus rather than straight income, the attorney took advantage of the FECA loophole which rules that a bonus cannot be used in making an income determination. The attorney also reported his income in such a manner that it was confusing to the employees of the Office of Workers' Compensation and as a result they did not understand the total amount of money he was receiving.

His compensation of $860 per month was terminated in January 1981 as a result of information we furnished to the Department of Labor.

Another case involved a claimant the files show was injured in July 1972 lifting a 4-ounce saltshaker. The file contained an August 1972 letter from the patient's doctor, which indicated a pre-existing back problem. The file also indicated, witnesses had said that the former employee had a shoulder injury and not a back problem.

In March 1973, the doctor indicated that he could have a 10-percent disability. No current examination was conducted from that time until very recently. As it turns out, his claim had been upheld because of the pre-existing injury and the recent medical evaluation.

A third instance involved a file which contains a 1980 letter from a doctor indicating that the patient could not lift her children with her right arm. Elsewhere in the file, it indicates that her children are 15, 20, and 22 years old.

Senator COHEN. If she could, we would really have a problem with steroid abuse at that point.

Mr. SILVERSTEIN. In January 1981, as a result of information we furnished, her benefits were terminated and they were $800 a month.

In another instance, the file contains letters from doctors in 1977, 1978, and 1980, all indicating that the claimant could work. Based on information that we furnished the Department of Labor, her compensation has now been reduced to $690 a month. The Department of Labor is collecting overpayments due in excess of $1,400 and they are in the process of rating her to determine her true employability. In another case, the last medical information in the file was dated 1973 and indicated that the claimant could work and there was nothing wrong with him.

Based on this information we furnished the Department of Labor, they are now taking action to terminate benefits of $704 per month.

All 77 of the cases indicating possible administrative shortcomings on the part of the Department of Labor were referred to the Office of Workers' Compensation through the Office of Inspector General at the Department of Labor.

As of July 14, 1981, the Office of Workers' Compensation had notified us of terminated or reduced compensation being paid to former employees only on 11 of the referred cases.

The monthly savings to the Government as a result of reduced or terminated payments on these 11 cases alone is $6,880 per month, or more than $60,000 per year. These figures do not include medical expenses paid by the Government on these claims and the actual savings is going to be much greater because the yearly sum would have to be multiplied by the number of years the employees would otherwise receive payments.

On July 19, 1981, the Department of Labor informed us of the status of an additional 35 cases. We have been told that in 4 cases the claims are being reduced, 12 are in process of being reviewed and in 19 of the cases the claims have been upheld after the information in the file was updated and reviewed.

We have been informed by the Department of Labor that action is still pending on the remaining cases referred to them and we anticipate significant additional savings when these actions are completed.

Cooperation by U.S. Department of Labor program officials during the course of the project was good. However, we have experienced some difficulty in obtaining timely action from them on the remaining 66 cases referred to them.

For example, we informed them of the results of our review and referred the 77 cases to them in December 1980. However, it was not until June 1981 that we were first notified that action had been taken on the 11 cases I previously referred to.

I would be pleased to respond to any questions.

Chairman ROTH. Let me ask you, it was 3 or 4 days ago they reported on how many additional cases?

Mr. SILVERSTEIN. On 35 cases in the Jacksonville office, July 19.

Senator COHEN. Could I ask one question before we move on?

Chairman ROTH. Yes.

Senator COHEN. In that instance where you mentioned the doctor telling you that the patient could not lift her children with her right arm, what was done with respect to that doctor's name as far as future FECA cases?

In other words, was there a note made that here we have a physician certifying that a patient cannot lift her children, and that is the end of it? Or what happened?

Mr. DAVIS. In the case of the letter involving the doctor, I advised the Department of Labor of the letter, the date of the letter, the name of the doctor and his comment. As far as what the Department of Labor has done, it has not been followed up because I have not been able to review the rest of the files.

Senator COHEN. Wouldn't that pique your curiosity as to a physician who is certifying that someone can't lift her children? Wouldn't that normally stimulate some curiosity as to what else he has been certifying with whatever other employees?

Mr. SILVERSTEIN. I would certainly agree. It is something that needs some followup on.

Chairman ROTH. Thank you, gentlemen.

At least two of you gentlemen indicated that the cooperation from the Department of Labor was less than wholehearted. As I recall, two

of you said you were able to get information only working through the Inspector General; is that a correct characterization of the relationship?

Mr. NELSON. That is with the Postal Service, yes.

Chairman ROTH. In other words, the cooperation between the VA and the office responsible for administration has been less than helpful?

Mr. NELSON. Between the Postal Service and the workers' compensation group, if for instance we need to review some files, say, in their Cleveland office, we have to contact one of their agents in Ohio or do it through headquarters to gain access to those files in Cleveland. There is often quite a substantial delay in the investigative process.

Chairman ROTH. Do I correctly understand there are occasions where the only way you get assistance or help is through the IG?

Mr. NELSON. The main portion of the time that is the case.

Chairman ROTH. Mr. Bradburn?

Mr. BRADBURN. Yes. We have had the same experience, generally, with our surveys. Initially, when we developed our survey outline, we approached an OWCP official in Washington to discuss the project. We advised him we had a series of criteria—fraud indicators—we would like to have applied to each of the files. Initially, we asked that OWCP claims examiners, due to their expertise, conduct the review for us. The official stated that wouldn't be possible due to the work load of the individual regional OWCP offices.

We then suggested gaining access on our own, and the official indicated a reluctance because of suspected or feared criticisms if OWCP files were opened up to outsiders.

We subsequently, went through the OIG at the national level and, since that time, have gained access to the files and have had cooperation.

Recently, we have had cooperation on the part of some OWCP officials. However, it is usually as a result of having coordinated with OIG.

Chairman ROTH. Mr. Silverstein, in your testimony, you mentioned the attorney who earned a $34,000 bonus while drawing compensation benefits as well as the claimant who was injured lifting the 4-ounce saltshaker. Had the Department of Labor reviewed these files prior to the Atlanta project to ascertain whether benefits were still warranted? Let me ask you the same question I have asked the others, how responsive were the program officials at the Department of Labor?

Mr. DAVIS. I can respond to that for him. I had no problems. I was with the Inspector General of Labor for 16 months and I ran a lot of cases. They knew me, I pulled the files myself, I had absolutely no problem. I cannot say what will occur outside the Atlanta region. But obviously I have had complete cooperation.

Chairman ROTH. That is with the Office of Inspector General.

Mr. DAVIS. Yes, sir, and I am with the VA now, but I was with Labor IG. So I knew these people.

Chairman ROTH. I gather all three are saying you got good cooperation from the IG, is that correct?

Mr. DAVIS. I am saying from the program managers as well. They knew me. I had no problem whatsoever dealing with them because

of my prior dealing with them. It is a little bit different than the others on my part.

On the question about the doctor and the 4-ounce saltshaker, the information is he had not been questioned by the Department of Labor concerning his income in detail. The law, as Mr. Silverstein mentioned, does say a one-time bonus cannot be used to determine the income.

When I interviewed the individual, I asked him why he reported it as a bonus—he had represented an employee in a worker's compensation case and he knew about the bonus situation—he said that it is a common practice in a law firm and he does that all the time and he reported it as a bonus.

Of course, when they read "bonus", they just filed the document. I obtained a copy of his annual earnings and a complete interview of him. When I returned to Atlanta, they terminated his compensation based on my information the day I came in.

On the 4-ounce saltshaker, the problem there was very simple, they had not had a current medical evaluation. Had they had a current medical evaluation, it would have made sense the lady had a preexisting back injury and the lifting of the saltshaker was not really the problem, it was a twisted back reaching for the saltshaker. The doctor said lifting a 4-ounce saltshaker. That is all I had to say.

Chairman ROTH. Yet some of our witnesses testified that claims processing could be improved if employing agencies would assist in providing full documentation on each claim. I wonder what each of your respective departments are doing to check on his own employee's claim. Would you care to start that out?

Mr. DAVIS. Of course, that is a personnel type action.

As far as as I know, once personnel submits a thing to workers' compensation, there is never any followup from workers' compensation back to the agency or the other way around. I know of no——

Chairman ROTH. There is no followup whatsoever?

Mr. DAVIS. To my knowledge, no, sir, I know of no followup.

Chairman ROTH. Mr. Bradburn?

Mr. BRADBURN. I cannot speak authoritatively for the personnel side of the Department of the Air Force, but my experience is that there are differing degrees of followup by individual Air Force civilian personnel offices.

Some of them are very much aware of their responsibilities. However, others don't really understand what the requirements are in general.

Chairman ROTH. So what you are saying is really there is no consistent policy.

Mr. BRADBURN. That is right, yes sir.

Mr. NELSON. The Postal Service has about 385 employees in the field who are injury compensation specialists. They are at about 150 locations, and they have a complete file on anybody that goes into the FECA program. They make contacts with physicians, they make contacts with the individuals when they are off work and they monitor them very closely, through, about 12 months after they are off COP and onto disability retirement.

Chairman ROTH. The suggestion was also made yesterday that the Department of Labor does not administratively exclude or debar medical service providers who have been indicted or convicted of fraud

from practicing Federal workers' compensation. I wonder if each one of you gentlemen would quickly comment on how you view the concept of debarment as a viable means to remedy fraud and abuse in the program? Would you care to start?

Mr. NELSON. I think it has some potential. I haven't really given it a great deal of thought. We are not aware of many repeat cases where physicians are once convicted of filing false claims.

Chairman ROTH. You say you are not?

Mr. NELSON. Pardon me?

Chairman ROTH. You are not aware of many?

Mr. NELSON. Not from our investigations, of many physicians who are repeaters, convicted once and come back again for the same thing.

Chairman ROTH. Has an investigation been made, to your knowledge?

[At this point Senator Rudman withdrew from the hearing room.]

Mr. NELSON. No; but I am sure through the way we check up on our doctors that are involved in FECA—we have fraud investigations, too, that would relate—insurance fraud maybe involving Blue Cross, Fireman's Fund, whatever they may be, and we cross-check the doctors involved in those fraud cases with the doctors involved in our FECA cases to identify situations that get involved in multiple claims. I don't know of one where we have had a repeat case on a doctor after they have been convicted.

Chairman ROTH. Yet the subcommittee staff testified that the Postal Inspection Service was instrumental in identifying medical service providers who had been indicted or convicted of fraud related to the provision of medical services. How many investigations of medical service providers has your agency undertaken in the past 5 years? And of these investigations, could you tell us the percentage of resulting indictments and convictions against the fraudulent medical providers?

Mr. NELSON. I would have to provide that 5-year figure to you later.

This current fiscal year we have 152 investigations open involving insurance frauds that relate to physicians. And I would also have to get you the prosecuting and conviction rate at some other time. I don't have that with me.

Chairman ROTH. Mr. Bradburn, would you comment?

Mr. BRADBURN. I cannot really comment on that beyond saying that our survey outline lists doctor/patient collusion as a type of potential fraud to address. However, with the exception of the medical provider I referenced in my statement, we have not surfaced any specific allegations concerning doctor/patient problems. I have definite feelings about the existence of such fraudulent practices. Unfortunately, we have not yet uncovered many instances in individual investigations.

Chairman ROTH. Mr. Silverstein?

Mr. SILVERSTEIN. If a doctor has been convicted of fraud in connection with the FECA program, in my opinion he should not be allowed to provide medical services to the Government in connection with health and human services programs or any other type of Federal health programs.

There is ample precedent for that. For example, in the loan guarantee program, VA has a loan guarantee program, and HUD has a loan guarantee program. If a person is convicted in one program as a result of filing false statements with VA, he is debarred from the HUD

program. There is also, I believe, other type of similar information. In terms of indictment as opposed to conviction, I do not know if I would say they should be automatically debarred. However, the fact of indictment, that a doctor has been indicted in connection with one Federal program, should be made available to other Federal health programs so that the name of the doctor is known and information he provides and the services he provides might be scrutinized a little more carefully.

Chairman ROTH. I must confess, I agree with my colleague, Senator Cohen, who has been doing yeoman service in this whole area of debarment of private contractors.

I personally can see no reason whatsoever that any doctor, guilty of some of the practices we have seen today, should be permitted to continue to provide such services.

To me it is just an open invitation to continue to abuse and defraud the Government.

[At this point Senator Rudman entered the hearing room.]

Chairman ROTH. I guess we will take them in the order they come, if you don't mind.

Senator Rudman?

Senator RUDMAN. I don't have any questions for these witnesses at all. I appreciate their testimony. It has been very informative.

Chairman ROTH. Senator Cohen?

Senator COHEN. I have a number of questions which I will perhaps submit for the record, since we have more witnesses to come.

Mr. Davis, I know it is a temptation on our part to seize upon a 4-ounce saltshaker to embarrass a department or a program, but let me just go back and refresh my own recollection and see if it is correct.

Under Federal law, and it may be a problem again not so much of abuse of the law as interpretation of the law, but as I understand it, if that woman had a preexisting injury prior to coming on the Federal payroll and she was working on the job 8 to 5 or 9 to 5, and she reached over and twisted to get a pencil, a saltshaker, a glass of water, a cup of coffee, under existing law, as long as she was in the course of her duties, she would be entitled to compensation as an aggravation of a preexisting injury; isn't that correct?

Mr. DAVIS. Yes, sir.

Senator COHEN. Originally as workmens' compensation started out, the interpretation was, there had to be a causal connection. In other words, there had to be some stress required by the job that had been different than if she had been home and reached for a cup of water. There had to be something unusual connected, heavy lifting, maybe a stretch that was required that is extraordinary. But now as I understand it, the existing Federal law says that as long as you are in fact injured on the job, or you do something that aggravates a preexisting injury, which involved no unusual strain or stress, you are still entitled to compensation.

Mr. DAVIS. Yes, sir.

Mr. COHEN. So in effect what you were saying is that the person who wrote that report or filed a summary of it used the phrase "lifting a 4-ounce saltshaker." But that really is an exaggeration of the nature of the claim, since what she really claimed was she twisted her back while on the job, period.

Mr. DAVIS. That is correct. This preexisting thing is really a headache to workers' compensation. I had an investigation one time where a fellow had hurt himself on a dock, unloading a truck, and the information I had was that he was installing screens by climbing ladders, and so forth. During my investigation, the witnesses that I interviewed were very reluctant to even talk to me. I later found out that the guy had a wooden leg. They had hired him to unload trucks with a wooden leg. It didn't even make sense to me. This is when I first came into this preexisting thing. So, obviously, they are not given physical examinations to document the preexisting injury so they can keep them away from areas where they may injure themselves again.

Senator COHEN. Even so, under existing interpretation of law, it is virtually impossible to deny a claim as the law is currently being interpreted.

Mr. DAVIS. That is correct.

Senator COHEN. If you have any kind of preexisting condition and a doctor will come in and say, yes, in response to a question from an attorney—and I used to represent claimants myself—"Doctor, is it your professional judgment that this type of twisting motion which occurred while this person was working on a Federal job could have, in fact, aggravated a preexisting condition?" And almost every physician will have to say medically that it is possible, and in this case quite probable, and therefore, the claim is allowed. Isn't that how it works?

Mr. DAVIS. Yes, sir.

Senator COHEN. So what we really have is a problem in going back to how the system is being abused in that it is virtually impossible to have any kind of method of determining whether or not someone comes on the job with a preexisting injury that was, in fact, aggravated by the nature of the job. In other words, what we turned it into is a system whereby if you have any preexisting ailment, just by virtue of being on the job, then that could have aggravated the ailment, and, ergo, you are entitled to compensation.

Mr. DAVIS. We accepted employment and now we are responsible—that is the bottom line.

Senator COHEN. One quick question, Mr. Chairman.

Mr. Nelson, we had testimony in the field of home health care abuses where financial intermediaries have indicated that if they conduct audits, they save the Government $4 for every $1 spent on the auditing procedure.

Are you in a position to make any kind of an estimation as to what sort of cost-effective result is produced by the postal inspectors' investigative efforts?

Mr. NELSON. Well, other than my prior testimony, in fiscal year 1980, we did identify cases that brought a cessation of $2 million in payments.

Senator COHEN. I mean in terms of the relations of the amount spent, what is in fact saved.

Mr. NELSON. No; I can't right now.

Senator COHEN. One of the problems I have with the current administration is that, when we are talking about cutting back the size of Government, we might, in fact, also be increasing the possibility of more waste. This is because we are reducing audits rather than in-

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1 OF 3

creasing them. I was wondering, in view of the fact that we are intent on reducing personnel, what is that going to do as far as your program? I guess what I am saying is, how are you going to overcome that?

Mr. NELSON. Our personnel right now will probably remain as they are. We do not foresee any reduction.

Senator COHEN. Mr. Chairman, I have some questions I would like to submit for the record. I know we have another panel coming up.

Thank you.

Chairman ROTH. Thank you, Senator Cohen. We would ask these gentlemen to answer in writing any further questions members of the subcommittee may care to submit to you.

I just have one final question:

I was interested in your comment, Mr. Nelson. You said you, to date, received two major areas which are in need of improvement.

One of those areas was the cooperation with the Department of Labor—so I won't dwell further on it. But it was interesting to me that you also say that the Veterans' Administration has experienced a great deal of hesitancy on behalf of U.S. attorneys to accept these kinds of cases for prosecution. Do you have any further information, I wonder, of how many cases have been submitted and turned down?

Mr. NELSON. We submitted all our cases where we have the evidence. The main thing is, like the continuation of pay—the 45 days—when we resolve them during that period of time and submit them, financial loss is relatively small. They are not an attractive prosecution from that standpoint. And generally, with our employees, they have no prior criminal records. They have been relatively clean and it is not attractive for prosecution from that standpoint, and they have all been terminated.

So the position they generally take is, the administrative action is sufficient.

Where we have had prosecution—there was one out West, maybe a year ago, when the individual was indicted and the following week I think we had 18 employees return to work who were on continuation of pay in one post office.

The publicity got quite a few of them thinking and they did return to work.

Chairman ROTH. As I understand your testimony, you think that if the U.S. attorneys offices were more aggressive, that this would be helpful?

Mr. NELSON. Absolutely.

Chairman ROTH. Do any of you gentlemen care to comment? Have you had any experience with the U.S. attorneys offices?

Mr. SILVERSTEIN. I used to be a prosecutor with the Justice Department for about 7 years. One of the things that the prosecutor looks for would be some dollar loss—that has jury appeal. And one way that agencies with cases in which the dollar amounts are not large can get prosecutions is to cluster a group of small cases, indict half a dozen, a a dozen cases, at about the same time. The publicity from that will certainly have a very effective deterrent standpoint and when the U.S. attorney gets six or seven, he has done a lot of the work on the first one for the remaining ones. So it cuts down on the amount of time he has to spend on a particular case, and by using the cluster effect, I think prosecutors will be much more receptive than perhaps they are today.

Chairman ROTH. Do you have any comment, Mr. Bradburn?

Mr. BRADBURN. Not in addition to what these two gentlemen have said, but I would like to go on record as saying I agree entirely with especially what Mr. Nelson indicated.

We are trying to cluster some of our cases now. Hopefully, that approach will help.

Chairman ROTH. I want to thank you gentlemen for appearing here today. As I indicated yesterday, we intend to continue to monitor what progress is made under this program and we will be back in touch with you at a later time to see what steps have been taken to strengthen the administration of this program.

Senator COHEN. Mr. Chairman, may I ask one question which again is not related to fraud itself. As I sat here and listened to some of the testimony—and I am not sure what the current law is right now—do you think we should have a provision that in helping to initially catch these cases, for example, with a preexisting injury, if a person is hired on the Federal payroll, they fill out certain forms? One form I assume would be a disclosure of personal health form. It would require the new employee to indicate any preexisting injuries or ailments. If we don't, we ought to.

Senator Rudman and I were just talking about the concept in the law that you take your plaintiff as you find him or her. We should at least be in the position of knowing the kind of plaintiff—potential plaintiff—we are about to take in the future. So, if a person does have a wooden leg, or if a person does have a preexisting case history, then that ought to be disclosed. Then, to the extent the claim is then an aggravation of a preexisting injury by lifting a cup of coffee, it seems to me there should be some provision in the law that says you are not entitled to compensation for aggravation of preexisting injury unless you disclose it. It seems to me there is no way we are going to get a handle on aggravation of preexisting injury unless you have a method of determining whether you want to hire that person and, therefore, take the risk you are employing a person who, down the road someplace, is going to make a claim for an injury.

You can slip a disc by sneezing on the job, and you can slip a disc by stepping off a curbstone. If it is in the course of your job, then, as we currently have the interpretation of law, you are entitled to compensation.

Are you familiar with the law today, Mr. Davis, as to whether or not that kind of certification is required?

Mr. DAVIS. To my knowledge, it is not in there. Along the same lines which you may also be interested in is the acceptance of additional medical problems after the individual's job-related injury has been healed.

If you understand the law, if three-fourths of your pay is tax-free and it is more than when you work, I would be depressed too, if I had to go back to work and make less money. Quite often, they accept additional medical problems after the injury. We have two medical problems here that really tie the hands of workers' compensation. It is very difficult for them to make a new rating on these types of cases.

I don't know what the answer is, but that is very common.

Senator COHEN. We have two problems: One is, how do you stem the floodgates at the beginning?

Mr. DAVIS. Yes, and at the end.

It is just as important at the end. We will accept—not we, but the workers' compensation physicians will accept depression, if a person has been on compensation for a period of time and a physician says your job-related injury is no longer the cause for you not working. Then they will accept depression or some other medical problem. Another is if the person is not employable because of education or prior experience, and they will continue him on because of that.

I tried to get those people into vocational training and I cannot do it. Their answer is they are unemployable; they don't have enough education. It has nothing to do with the fact the injury is no longer the cause of not working. We have a lot of problems in the medical area. Once it is accepted, there is nothing OWCP can do if the doctor says it is related. They do this quite often.

Senator COHEN. That might be one proposal we can make to a different committee to perhaps have a reexamination of the criteria for awards of compensation or the criteria for hiring practices. If there is no disclosure of a preexisting injury, it seems to me unconscionable for a person not to disclose it. But if it is required and you don't disclose it, you ought to be barred from being able to say that lifting a cup of coffee has caused aggravation of a preexisting injury. Otherwise, there is no way of getting control of it.

Mr. DAVIS. It could be a thousand and one violations.

Senator COHEN. Thank you, Mr. Chairman.

Senator RUDMAN. I wanted to add, to follow on Senator Cohen's comments, what Senator Cohen is talking about is common to the private sector. The physical examination of disclosure requires any preexisting illnesses and injuries to be disclosed. This does not say private employers don't employ people and take them at risk. Private employees tend to keep in mind what that disclosure shows. If we don't do this, then you bring in someone with a preexisting back injury and put them into a warehouse installation where they are operating forklifts, there is a high risk to the Government that that person will become seriously injured, which then, of course, is compensable under any law and State. It seems to me the question Senator Cohen has raised, which I did not realize before this hearing, was that maybe we ought to talk to OPM at another meeting, in another context, to see whether or not we can do some of the things that are done in the private sector.

The fact is the Federal Government does employ people and will knowingly employ people—in my opinion, should employ people who have previous injuries and illnesses. Certainly we want to do that, but do it with more care. We certainly don't want to put a person with that kind of back injury into a position that would aggravate it in a shorter period. I think we ought to look into that.

Chairman ROTH. Thank you, gentlemen.

Our next witness will be Mr. Ralph E. Hartman, Director of the Department of Labor's Office of Workers' Compensation Programs.

Please raise your right hand. Do you solemnly swear to tell the truth, the whole truth, and nothing but the truth, so help you God?

Mr. HARTMAN. I do.

Mr. KOWITCH. I do.

Mr. DONOGHUE. I do.

Mr. MCLELLAN. I do.

Mr. MARKEY. I do.

Chairman ROTH. Please be seated, gentlemen.

Mr. Hartman, I would appreciate it if you would identify each one who is accompanying you and for background information advise us as to the position and how long each gentleman has been with the FECA administrative office.

TESTIMONY OF RALPH E. HARTMAN, DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, U.S. DEPARTMENT OF LABOR; ACCOMPANIED BY JOHN McLELLAN, ASSOCIATE DIRECTOR FOR THE FEDERAL EMPLOYEES FEDERAL COMPENSATION PROGRAM; THOMAS MARKEY, DEPUTY ASSOCIATE DIRECTOR FOR THE FEDERAL EMPLOYEES FEDERAL COMPENSATION PROGRAM; LAWRENCE KOWITCH, ACTING DEPUTY DIRECTOR FOR POLICY PLANNING AND STANDARDS; AND CORNELIUS DONOGHUE, ACTING ASSOCIATE SOLICITOR FOR EMPLOYEE BENEFITS PROGRAM

Mr. HARTMAN. On my immediate right is Lawrence Kowitch. He is Acting Deputy Director for Policy Planning and Standards, who has been with the Federal Government for more than 25 years. He has been with OWCP for just over 2 years, but has been involved in certain task forces involving OWCP for the last 8 years.

On his right is John McLellan, who is Associate Director for the Federal Employees Compensation Program. Mr. McLellan came to the national office in January 1978.

Prior to that, he had been Assistant Regional Administrator in New York and had served in New York under the longshore program before he became ARA for more than 20 years.

On his right is Tom Markey, his deputy, Mr. Markey has been with the federal system, Tom, how long?

Mr. MARKEY. Eight years.

Mr. HARTMAN. A total of 8 years. He has been Assistant Deputy Commissioner in charge of FECA district office 25 here in Washington and came to the national office about 18 months ago.

On my left is Cornelius Donoghue, who is Deputy Associate Solicitor for Employee Benefits, the counsel to the Office of Workers' Compensation Programs. Mr. Donoghue, how long have been in service?

Mr. DONOGHUE. I have been in the Government 21 years and associated with the workmans' compensation program for 8 years.

Chairman ROTH. Mr. Hartman, before you start out, let me say that I am deeply concerned about what I consider the lack of internal controls in this program. I think, if anything, one would characterize it as almost being gross negligence.

I am concerned, if you look back to a statement that was made on April 14, 1978:

> Secretary of Labor F. Ray Marshall yesterday announced a crackdown on corruption and mismanagement and financial abuses in his department, including the Federal Workers' Compensation Program. Marshall said he established an Office of Special Investigations in the Department with a staff of 200.

Another article written by Richard Snyder of the Cleveland Plain Dealer on June 22, 1978, had the following to say:

A confidential audit by the Labor Department of its own Federal Workers' Compensation Programs reveals that 41 percent of disability claims paid were invalid and should never have been approved.[1]

Mr. Hartman, it is practically 3 years later, and the testimony that we received, and our own investigation that has been made, indicates that a great deal of corrective action has not been taken.

I just want to underscore that the purpose of this investigation is to insure that remedies be taken and be taken promptly, but before we get into that, I would like to give you the opportunity to make your statement or any comments you care to make.[2]

Mr. HARTMAN. Thank you Mr. Chairman.

I, of course, appreciate the opportunity to appear before your subcommittee today to discuss our efforts to reduce fraud; and let me say at the outset, I share your concerns. I am aware of the problems, just as you, through your investigation, are aware of the problems.

I could probably add more to the horror story type cases than your investigations have revealed. But I do want to assure you and the members of the subcommittee that the Department of Labor is committed to improving the performance of the Federal employees' compensation program. It is receiving a high priority within the Department of Labor, and in particular within the Employment Standards Administration, even under these restrictive times. We are not losing as many people out of the Federal employees' program as we are, for example, in black lung and the Longshore Act. There is an attempt to try to preserve what we have in the FECA program.

There have been a number of witnesses, including your own investigative staff, and I have no intention of denying many of their findings. But I must say that we would not, nor would your investigators, have been able to locate these cases in the sense of having definitive information without the capability which the delayed computerization of this program has finally made available, although at a slow and only moderate pace. I think Mr. Cox and Ms. Hainer would be inclined to agree.

I would just like to make one or two points of the progress we have made. It is only in recent years, beginning late in 1977, more emphatically in early 1978, that any concerted attempt has been made to turn around this very complex program serving a clientele of approximately 3 million Federal civilian employees, most of whom are domiciled in the continental United States.

The program provides coverage of activities of various agencies of the Federal Government abroad and within the continental United States. It is a broad coverage program. And in essence, it has been, and to a great degree still is, a mail order-type business, and that is regrettable.

I concur with and accept many of the statements of those who testified earlier today. Our cooperation with the Postal Service, their assistance and that of the Air Force, and with the Veterans' Administration, has improved greatly over the past year or two. I must say, however, that there is still a basic reluctance in many of the agencies to reemploy, to return injured employees to work as quickly

[1] The articles referred to appear on p. 231–233.
[2] The prepared statement of Mr. Hartman appears on p. 139.

as possible. I would like to make the FECA the Federal employees' reemployment program and get away from the sole focus on dollars that seems to prevail not only in the public sector, but in the private sector. We need to be concerned less with how much an injury is worth, and concentrate more on what needs to be done to get the injured worker back to gainful employment. We need to return to that concept.

We have done a number of things to improve FECA. I came to this job in January 1978, and a conscious decision was made very shortly thereafter that the major thrust should be to reduce the number of active long-term disability cases and thereby achieve three objectives: No. 1, reduce compensation costs; No. 2, reduce medical costs; and No. 3, get the injured workers back to work.

We started in 1978. In February 1978, I called the first quarterly meeting of the representatives of the agencies in Washington and we have held those quarterly meetings consistently since. At that first meeting in February 1978, one comment that was voiced by one person and concurred in by almost every representative of the respective agencies there, was that "our understanding is that the agency is to do nothing except report the injury to the district office having jurisdiction of the Office of Workers' Compensation Programs."

I found that was the general conception within that group that was there, and it may have been a little overdramatic, but I looked at my watch and I saw that it was 10:15, as I recall, on February 16, 1978. I said, "If there is any such document or any understanding that such a document exists, let me cancel it at this very moment."

Then we went on to discuss the responsibilities, and there has been tremendous improvement and it is only with the assistance of the agencies that we can do an effective job. Keep in mind that the present law and the procedures contemplate: (1) that a claimant reports an injury to his employing agency to and through whatever channel that agency has established; and (2) that agency reports it to the district office of FECA. We know nothing in our district offices, unless something is in a local newspaper or these is a catastrophe.

For example, we know when there is a major airplane crash in this country there is a probability that there are one or more Federal employees among the passengers on that plane. We know, for example, in the Forest Service, that when there is a headline of a small plane with 22 smokejumpers aboard that crashes, we know almost immediately. We know when a grain elevator down on the gulf explodes, we know there are going to be some Federal employees there.

Last year we received 220,000 reports of injuries scattered geographically across the country. Some 34,000 to 35,000 specific claims were filed, but among those 220,000 cases reported, there was in excess of 100,000 involving some continuation of pay.

Our record shows continuation of pay has averaged 11 days in the last year. But the amount the agencies paid last year was in the neighborhood of $70 to $75 million, so that the cost factors are there, and agencies have a stake in reducing these costs.

I was given a challenge. Whether I met it or not is for people like you to determine. But I found this organization in a virtual state of collapse. There had not been a director for a year and a half. There had been an acting director. The associate director for the Federal Em-

84-776 O - 81 - 7

ployees' Compensation Act retired the month before I arrived and I asked him to come in to find out a little more about his organization. I couldn't avoid the sense that he had retired some years before his actual retirement date.

When I asked, "Do you have anyone in mind for this position?"

"No, not really."

Or, "Can you give me some names that you would consider if they were here?" (He did not have an assistant and hadn't had one for several years.) "Not really."

When I said, "Could we go down through the organization?" "Well," he said, "you can't go below a grade 14 because this is a 15 position." I admit I knew enough about the Government in my limited exposure to it that that is essentially true. But I asked, "What, sir, what about this 13, what about this 12, what about this 11?" "Oh, they aren't eligible."

I said, "I am not talking about tomorrow; I am talking future tomorrows, "what planning has been given to not only improving the current organization but building it up, finding the people that can do the job, that are willing.

When I came in, I found a very frustrated group of people. OWCP has been much maligned. I think that the attitude has changed, at least among the constituency with which we deal. Our congressional correspondence, our employee correspondence, and our medical provider complaints have declined considerably over the past 2 years, indicating an overall improvement in FECA responsiveness. We made a great many personnel changes since 1978, but the difficulty of changing positions, more particularly changing people who are in positions in the Federal sector, is not the easiest thing to do.

In many instances, short of bringing charges which involves sometimes years of substantial amount of time to perfect them, I have convinced a number of people to retire. I have convinced a number of people to take downgrades or to transfer.

Now, with respect to billing, I said we moved initially into the periodic roll. Now much of what was said here within the hour is clearly true. We have an excellent working relationship increasingly with the agencies and particularly with the Postal Service.

[At this point Senator Cohen withdrew from the hearing room.]

Mr. HARTMAN. With respect to cooperation with the agencies on their investigations of questionable claims, there is and was no need for them to go through the OIG to see a file involving an employee of theirs. They did not come to my office with respect to the Atlanta project. I learned of it later and the files were opened to them. And while I appreciate that the OIG arranged for that opening, there was no reason why the agency could not have come to me and they would have had the same cooperative assistance.

The concern, because of the pressures to process claims that it was on, beginning in 1978, is because of the tremendous backlogs. Because of the freeze, losing people repeatedly, particularly the Department of Labor, it was not a 1-for-2 under the freeze that began in early 1980, the Department of Labor and in particular with the employment standards administration. it was 1 for 4 so we had difficulty in maintaining an organization—but we have changed. We want to cooperate. I value the input whether it is from the Postal Service, and let me say

that almost everything the Postal Service has done has been with our approval, with our encouragement. We have probably worked closer with the Postal Service than any other agency because when they announced here this morning, or at least reported this morning of their 300 some workers' compensation investigations specialists in the field, they are in position to do that. It may increase the price of our stamps, nevertheless they are in the position to do it.

In the fiscal 1977 budget for OWCP, there was approval for the employment of 22 investigators. We have no investigative capability in OWCP and within my memory they never have had any. In January when I came there, 2 of the 22 slots had been filled.

Shortly thereafter, the Office of Inspector General was created throughout the Government and immediately those 22 slots were taken from OWCP, and transferred to the DOL Inspector General, including the funding for the full 22 positions. We still don't have an investigating resource at the OWCP level, not necessarily to find fraud in the legal sense, although it may result in that, but to interview people because as I said earlier, we do too much by mail, and secondarily by telephone.

There is no direct discussion with an injured person. I have been through this in the private sector. There are many things I would like to do, but we cannot do. One of the real concerns has to do with employer-employee relations. I referred earlier to the quarterly meetings with the agencies, to our insistent attempts and gradual acceptance of a cooperative effort with the Postal Service and the Air Force. TVA is an excellent example of total cooperation, but one of the things that has made that work is the fact that they have centralized their claim and medical services in their direct service States and two or three others on the fringes of their service area. They have centralized the processing of all their claims, in a claims division. A great many of the agencies do not have a claims division in the sense that a commercial insurance carrier, for example, or a large self-insured employer, so that everything is reported in to them.

We are working with them now to experiment with tying them into our computer system because we can tie them into Atlanta or Jacksonville, from Chattanooga without a great deal of expense, so they would report their injuries by computer.

We have already had similar discussions with the Postal Service. They are working toward it. I don't want to talk about their costs, but there is an indication that if we can develop this thing, that they will assume the cost of all of this equipment, the screens that they need, and the basic input data equipment that is needed. Clearly the illustrations and examples of cases—Dr. Kones, Dr. Josephs, Dr. Dent, even Tick Tock Pharmacy, those were found—well, two of the doctors in New York, one Dr. Dent in the District of Columbia. I am sure there are many, many others.

With regard to fraudulent medical billings in the New York area, your own investigations came up with a list of 20 doctors, identified 3 that were really questionable. Two that were extremely questionable in their continued practice of charging for services and treatment not rendered. Dr. Kones charged $600 for an office visit. That even would attract my attention if I were reviewing a bill for payment, but it didn't. It was a failure of our system, it was a failure of our super-

vision, it was a failure of our management, including me. We have made changes in New York. The regional administrator was acting at various times as the assistant regional administrator. Perhaps you are aware of this, so forgive me if it is repetitious, but the Department of Labor has 10 basic Government regions. They have a regional administrator in each of the regions, and then an assistant regional administrator for OWCP, similarly for Wage-Hour and for Office of Federal Contract Compliance.

Changes have been made on two occasions in New York since I have been there with the assistant regional administrator. Changes have been made with the Deputy Commissioner running the FECA program.

Changes have been made with the supervision in the bill payment section. in the quality control section. Too many low-grade employees not sufficiently trained, not sufficiently supervised, no preaudit or postaudit of what they are approving, I admit it. It was there and to a degree still remains, not only in that office, but across the country. But as I recall, the statements from Mr. Bradburn from the Air Force with respect to their Atlanta survey, and the others generally agree they had not found—I think they conditioned that upon the fact they had not looked specifically for it, but they found no evidence of impropriety with respect to medical providers.

I think if they looked a little harder, they probably would have found some. We find some.

One of the questions with respect to physicians, a question of disbarment, the question of an interchange of information among agencies, we have no way at this point of knowing when a physician is up on charges for whatever reason under another Federal program, or whatever. Every instance that we find, we report it to our Inspector General, to his regional district offices over the country. We reported Dr. Kones when we discovered that, belatedly he had been paid $120,000, a substantial amount of it, totally improperly. Checks were found in his files including FECA claims that he had not yet cashed. We were not advised of those findings until after all of this had transpired, but in the course of the investigation, they found a great deal of evidence that tied him into the Federal Employees Compensation Act.

We were not aware of it. We need to develop a reporting system. Medicare has its problems; I think every benefit program, Federal Government, the public sector, has its problems. A great many people talk about the malingering claimant, the percentage of the malingering claimant is at the low end of the totality of those who file claims or allege injuries. I think it is a minimum number of physicians and other providers, but those that are there, it is our intention that we move to prevent it, and then to apprehend and report for prosecution and where it is warranted, for indictment, conviction, and whatever further actions is appropriate.

I have no argument with respect to your findings, your general statements, the tenor of your questions, no problem except that it is a problem that all of us must mutually try to resolve.

The further investigation that the DOL's Inspector General is going to follow across the country which principal agencies, some of whom would be the same that were involved in the Atlanta project—I

support that. I shall give them every assistance we possibly can. I shall have some difficulty with the district offices simply because of their tremendous workload and a diminished staff, but it can be done, it will be done. There shall be no roadblocks thrown into investigations as far as I am concerned with respect to OWCP, whether in the national office or in any of the district offices, of which there are 16.

I want to know, and then to the extent of my authority and my ability, I will take the appropriate action to prevent. The agencies, I think, can play a very, very significant role. It has been suggested, for example, to have the provider submit the bills to an office designated by the agency in the geographic location where the injury has taken place and the medical service, pharmacy, hospital, has been given. That would take quite an organization.

I think, for example, the Postal Service could do it more rapidly because of the organization that they have already established.

Rather than investigating after the fact, that would permit these agencies to be a part of the process. And it has been my desire and my intent to bring the agencies more and more into the process.

As I said earlier, the question they apparently all understood, at least in their field of establishment, was don't do anything with the claim. I think the agencies, the same as any other employer interested in the welfare of his employee and in his costs, when there is an injury, I think it is a basic requirement that an employer take an interest and inquire as to what is wrong and what needs to be done to assist. It's too late when we get the report of that alleged occurrence 30, 60 or more days after the fact. That is the time to look at it.

As a matter of fact, under the present statute with continuation of pay, I wonder how much continuation of pay in dollars is paid to what number of people merely because nobody checks on employee absences. The person comes back a week later, they have had another 7 days of leave; and it has been alleged a great many people under COP assume and take those days the same as they do their annual leave and their sick leave. It is just another paid leave approach.

As far as I know, there are no basic statistics on that, but I think the frequency of the occurrence and for the type of conditions would indicate that perhaps the injury, real or alleged, was not sufficient to stay away from work for 7 days.

As to doctors, and I know you don't want to hear about what our computerized plans are for 1984, or whatever it may be, we have increased the working quality by the changes in supervision—you can't put higher grade people into these jobs, but we have additional supervisors in New York and elsewhere.

The thrust of your investigation has been in New York. Let's keep in mind that New York, the Big Apple, I love New York, take any slogan you want, New York is basically a claims-conscious community, more so than a great many other geographic areas or metropolitan areas in the United States. Of the percentage of injuries reported in New York, there are more lost time cases, a higher percentage of the injuries reported resulting in lost time than any place in the country. That is true not only under the Federal Employees Act but it is also true under the Longshoreman's Act.

It is a matter of the benefit level that tempts some to stay off work. Reference was made to the fact there is no incentive to return to work

where you can stay away from work and receive 75 percent of your gross pay, nontaxable, no deductions of any kind from it.

There are days—last night, about 9 o'clock, when I left the office, just going through all of this, it suddenly dawned on me, you know, that might be a way out of it, if you can draw 120 percent of your take-home pay. And when was that determined? In 1978. I don't want to inject myself as an individual into all of the accomplishments because it is not true, it cannot be supported. It is with the help of a great many other people, but by the same token, there has been a degree of motivation with people.

Nonetheless, I believe we have begun to turn the attitude of people around, especially the agency staffs. They were beginning to become resentful of criticism; but they are beginning to change their attitude. We have given them something to work for.

The amount of money involved in step increases the cash awards, so few and far between that there is no basic way to recognize people unless there is an opportunity to promote from one grade level to another, and that is becoming increasingly rare. But we have a very basic concerned cadre of people in OWCP. You may think it is a little—your investigators, Karen or Howard may have discovered this, but last year simply to make the talking point when I visit these offices and talk to our own district offices and talk to them to encourage their additional devotion and sincere dedication——

Chairman ROTH. You have been talking quite long and I don't want to cut you off. I would appreciate it if you try to sum up whatever additional comments you want to make.

Mr. HARTMAN. I can sum up by this statement, Mr. Chairman, and that is, we are sincerely dedicated to improvement in this program and my colleagues and I will be very happy to answer any questions you have.

Chairman ROTH. Mr. Hartman, if I understand your testimony, you do not disagree with the statements made that this program is badly in need of internal control; is that correct?

Mr. HARTMAN. I quite agree.

Chairman ROTH. Let me ask you one additional question before we get into some of the details, you also are responsible for the administration of the longshoreman program as well?

Mr. HARTMAN. Yes, sir, and of the black lung.

Chairman ROTH. Black lung, yes. Would you say you find the same kind of problems in those two programs that we do here?

Mr. HARTMAN. Let me distinguish just for a moment, the longshoremen's program. We administer that program the same as a State workmen's compensation board or commission would. We pay no benefits except under the special fund.

It is a claimant-employer insurance carrier relationship. It is a voluntary payment act. The same basic problems with respect to medical providers exist there, but that is something that is essentially resolved between the employer, his insurance carrier, and the claimants and the medical community.

[At this point Senator Cohen entered the hearing room.]

Mr. HARTMAN. Black lung is an entirely different program. It is an occupational disability act involving a single disease. There are medical provider problems there, we had difficulties with it. We are gradually getting it under control.

Chairman ROTH. I have to be very candid with you. One of my concerns is not with your intent but with the fact that everything seems to be off in the future at some late date. I find it very difficult to look back 5 years to 1976 and see what real progress has been made in instituting internal reform.

Let me ask you, for example, in your written testimony you say that the Department of Labor Division of Medical Services and Standards has developed medical guidelines to facilitate claims adjudication. Are these guidelines in writing?

Mr. HARTMAN. Mr. Kowitch.

Mr. KOWITCH. Sir, those guidelines are essentially detailed procedures as to the kinds of evidence and kinds of reports and procedures that physicians are supposed to submit and follow in connection with the claimant's injury report.

In effect, we are no longer satisfied with statements by a physician such as "the claimant is under my professional care." These guidelines, these procedures specify just what is expected of a physician in reporting the nature of the injury: The likely circumstances as far as an employee's future time off the job, as well as the kind of treatments and the kind of examinations that were given to the employee as part of the physician's examination of the employee. So these are much more specific.

Prior to these guidelines being issued——

Chairman ROTH. Who were they issued to?

Mr. KOWITCH. These were issued to the district offices.

Chairman Roth. I would have to indicate that our investigation has shown that no such guidelines have ever been issued into the field. But in any event, you say you are not satisfied with them. What are you doing about that now?

Mr. KOWITCH. I didn't say that we are not satisfied with them, Senator. I would say that these guidelines must be enforced, in the sense that if physicians fail to comply or produce the kinds of information that we request of them, it is up to our staff to go back to them and get better information.

Chairman ROTH. You are not satisfied with the enforcements of these guidelines?

Mr. KOWITCH. In that sense we have to do a job with our own people——

Chairman ROTH. What steps have you taken to correct that situation?

Mr. KOWITCH. We do our own internal monitoring of claims. We have periodic reviews, we try to identify gaps in that kind of documentation, and we try to present the——

Chairman ROTH. Let's be a little more specific. Exactly what specifically have you done in the last 6-month period to enforce these guidelines? Have you given any written instruction?

Mr. KOWITCH. There are written instructions——

Chairman ROTH. Were they issued within the last 6 months?

Mr. KOWITCH. I would have to defer to Mr. McLellan.

Mr. McLellan. In addition to the low back guidelines, we have two low back projects going to determine the best way of handling these cases probably the largest reported injury-type case.

We tried a project in the District of Columbia and in San Francisco. We take cases that are reported on low back injuries, and if it looks like the person is not going back to work within 30 days, we refer them to a specialist. This procedure is one of the many that we instituted since 1978 that has resulted in substantial savings to the agencies. The Postal Service and the Government Printing Office tell us that their claims fell down dramatically after we instituted this program.

This is one of the programs we have instituted since 1978.

Senator Cohen. I am sorry, do you mean the institution of the program of referring them to a specialist?

Mr. McLellan. No; to pick up on cases early on. What we are trying to do is adjudicate the cases earlier. We think the earlier we get to them the more money, dollars we will save. The claimant has a right to go to a doctor of his choice, and in the normal events would do so and be treated for a long period of time. What we are doing is following up on these cases early, about the third week. And if it appears the claimant will not go back to work in 30 days, we are sending him to a doctor of our choice for evaluation so we can see that if the claimant needs good treatment, he gets it. We can refer him some place else, if he is not getting it from his doctor.

Further, we can see he is taken off the rolls, off COP or compensation.

Chairman Roth. How many cases have you referred to your doctors?

Mr. McLellan. How many cases?

Chairman Roth. Yes.

Mr. McLellan. To outside doctors?

I don't know the total number going on in the District of Columbia offices.

Chairman Roth. Going on where?

Mr. McLellan. The District of Columbia Compensation Office.

Mr. Hartman. We can supply you with those figures, Mr. Chairman.

Mr. McLellan. I can't give you those figures offhand.

Chairman Roth. You are originally from the New York office; is that correct?

Mr. McLellan. Yes, I was there; right.

Chairman Roth. Would you be surprised to hear that these guidelines are not available in the New York office?

Mr. McLellan. Well, they are not distributed to all offices. They were just distributed very recently, but we are testing them first.

Chairman Roth. I must confess, I am a little confused, I thought these guidelines had been issued and distributed.

Mr. McLellan. They have been distributed.

Mr. Markey. They have been distributed to all offices. They are not using the exact procedure whereby they refer out to a university-based physician. However, the covering memorandum that went out with the guidelines indicated that these are the types of questions that should be asked of regular physicians.

We have had a problem asking physicians legal-type questions such as, "Does aggravation cease?" In the lower back guidelines, these types of questions are more in medical language that doctors better understand and we get better responses.

Chairman Roth. When were these guidelines issued?

Mr. Markey. They were issued a least 6 months ago. I do not know exactly what the New York office did with them, but I do know they received a copy of those guidelines with a covering memorandum.

Chairman Roth. I understand from Mr. McLellan that these are really part of a pilot test. Is that correct?

Mr. Markey. The complete guidelines—in other words, how it works is after 30 days, we have a relationship in the District of Columbia with George Washington's Orthopedic Department. We refer a patient and he sees that physician; the physician comes in with a report on his medical condition. That is not happening in offices other than New York—I mean Washington and San Francisco. But the guidelines in terms of some of the types of medical questions the office should be posing to physicians were distributed generally 6 months ago with a covering memorandum and New York was told to use that.

Chairman Roth. We would like you to submit a copy of those guidelines and the background instructions.

Mr. Hartman. We shall be glad to.

Chairman Roth. Mr. Hartman, you stated, I believe, in your written statement that Department of Labor procedures recommend the use of State workers compensation fee schedules as guidelines; is that correct?

Mr. Hartman. Yes.

Chairman Roth. Is that part of the same guidelines?

Mr. Hartman. No, this has long preceded that. This has been in effect for several years.

Chairman Roth. Again, let me say in the regions we contacted, we never saw any use of fee schedules of any kind. What offices are following through on that guideline, do you know?

Mr. Hartman. Mr. McLellan?

Mr. McLellan. What happens in bill pay is, they pay the customary fees in that area and if there is a question arising, they go to the guidelines. Some offices you have more than one State. Like New York, for instance, New York State has a fee schedule that is very detailed and is considered very low compared by doctors in New Jersey, for instance.

So it is very difficult to use a very detailed fee schedule in an office such as New York or some other offices, where there is more than one State involved.

Chairman Roth. Did the New York office use such a fee schedule when you were there?

Mr. McLellan. Used it as a guide; yes, sir. When a question came up by a doctor, when we questioned it, we went and looked at the New York State fee schedule if the doctor was in New York.

Chairman Roth. Are you personally acquainted with what each of the offices does with respect to these medical fees schedules?

Mr. McLellan. No, not on a day-by-day basis.

Chairman Roth. No, I mean as a general practice. Do you know for a fact that each office does use such fee schedules?

Mr. McLellan. I can't tell you offhand.

Chairman Roth. Are you the administrator of the program?

Mr. McLellan. Yes.

Chairman Roth. If you can't, who could tell us?

Mr. Kowitch. The fee schedule is not mandatory but it is used by the offices; it is a guide and the offices have to make judgments with

regard to the specific physician's claims fees based upon what the physician's own customary fees are as compared to those guidelines.

Chairman ROTH. Let me ask this question: Do you think it is advisable for the offices to have some kind of fee schedule to assist in cost containment?

Mr. MCLELLAN. We think there should be set standard amounts of money for medical procedures and for the length of time a person is treated under certain medical procedures.

Chairman ROTH. What are you doing to pursue that approach?

Mr. MCLELLAN. Well, by October of this year, we will have a formal training program out which will set up basic guidelines for medical procedure and length of treatment. It is not just a matter of fee schedule, it is a matter of treating on a continuing basis, so it is a matter of setting up basic fee amounts for usual treatment conditions and setting up a period of time when treatment can be——

Chairman ROTH. Are these going to be mandatory at that time?

Mr. MCLELLAN. Yes, it is going to be mandatory. Yes. That is the manual system.

We are building an automated system to use down the road. We are going to put out in something in place before that. We are now developing a computerized system where both the claims examiner and bill payer have to go through a structured decisionmaking approach. They will have an ADP screen in front of them; a CRT screen in front of them, so when they enter a bill or claim there will be a certain procedure they have to follow in adjudicating that claim in order to pay it.

They have to go through the computer. If they don't go through it right, they can't pay the claim. We are getting a structured approach that will require the examiners and bill payers to go through the procedures and they can't pay the claim if they don't go through those procedures.

That is what we are building.

Chairman ROTH. I would just point out in your written statement you state that fee schedules would be implemented in fiscal year 1984 as part of an upgraded ADP system. I might also point out that in October 1980, in response to an Office of Inspector General recommendation, Mr. Hartman's office stated that fee schedules would be obtained and provided to all the district offices by January 1981.

Mr. Rudman, did you have a question?

Senator RUDMAN. When you are completed.

Chairman ROTH. Mr. Hartman, you remarked in your oral testimony about the importance of close cooperation and your responsibility to work with the various departments and agencies; is that correct?

Mr. HARTMAN. Yes, sir.

Chairman ROTH. Yet the thrust of the testimony before you has been that there has not been a very good working relationship between the employing agencies and your own office, that in many cases they had to go through the Inspector General in order to get the kind of cooperation or the papers that they needed. You said if that had come to your attention, it would have been otherwise.

But isn't it a fact that this should be understood at every level of your operation?

Mr. HARTMAN. I think at this time it is clearly understood because you are quite right, it should be understood.

Chairman ROTH. You say you think that it is now understood?

Mr. HARTMAN. I hope so, because it has been fully stated by me.

Chairman ROTH. What kind of instructions have been issued to insure the implementation of this policy?

Mr. HARTMAN. Direct advices through the regional administrator to the district offices.

Chairman ROTH. Was this in writing?

Mr. MCLELLAN. We instructed the district offices to cooperate with investigations.

Chairman ROTH. That wasn't my question. I asked were these instructions put in writing?

Mr. MCLELLAN. Yes, sir.

Chairman ROTH. Would you submit a copy of those recommendations?

Mr. HARTMAN. Yes, sir.

Mr. WEILAND. Let me direct this question to Mr. Donoghue, if I might. Is it clear then, counsel, that there is no Privacy Act impediment or some other impediment to the providing of information to various OIG offices?

Mr. DONOGHUE. The Department of Labor, when they issued their system of records under the Privacy Act, did provide an expressed routine use for disclosing FECA files to the employing agency. There is also, as you probably know, a general routine use that is applicable to all Privacy Act records in aid of civil or criminal enforcement. The only thing that we would request from an agency is that the investigative body make a specific request in writing. That we followed the Justice Department request on that.

Chairman ROTH. Senator Rudman?

Senator RUDMAN. Thank you, Mr. Chairman.

Mr. Hartman, after listening to your lament, if we were to summarize the results of this hearing in one sentence, we would say that you are trying very hard, but right now things are in one hell of a mess. Is that a fair statement?

Mr. HARTMAN. That is a fair statement; yes.

Senator RUDMAN. Mr. Hartman, what is your background, your business professional background prior to assuming this position in 1978?

Mr. HARTMAN. I was a member of the Benefits Review Board for 4 years.

Senator RUDMAN. This is within the Department of Labor?

Mr. HARTMAN. Which was created in the 1972 amendments to the Longshoreman's Act and by reference is the appeal procedure under the Black Lung Act. The Benefits Review Board in that procedure replaced the Federal district courts in the appeal procedure. For 35 years prior to that I was with Bethlehem Steel Corp. in safety, health and in insurance, all phases of insurance, casualty.

[At this point, Senator Roth withdrew from the hearing room.]

Mr. HARTMAN. In charge of their self-insured program.

Senator RUDMAN. I assumed that from some of your statements. So it would be fair to say that you have had a chance, you have had more

than a chance, you have had 35 years' experience looking at how the private sector handles safety-related questions, including insurance questions, disability and medical payments connected thereto.

Mr. HARTMAN. Correct.

Senator RUDMAN. Would you agree with me that we do a pretty poor job in the Federal Government compared to the way the private carriers administer these programs?

Mr. HARTMAN. In a broad concept; yes.

Senator RUDMAN. Mr. Hartman, I want to turn to the written statement that you submitted to us and I have read. On page 14, you spend some time talking about increasing your efforts, contact with the medical community to find those doctors who have questionable practices, and so forth. Then continuing on page 15, at the bottom of the page, you say, "We do not currently have in place a mechanism to disqualify questionable medical providers or to exclude such providers from participation in the program."

My question to you, sir, is simply this: Since the date that you have assumed this responsibility, have either you or your superiors recommended to the Secretary of Labor that a debarment proceeding be established so that those physicians and those providers who, in fact, have been proven to have committed fraud in courts either State or Federal, short of being delicensed, in fact are barred from doing business with your agency? Have you made that recommendation?

Mr. HARTMAN. It has been discussed, but as a firm recommendation, no.

Senator RUDMAN. Why?

Mr. HARTMAN. I think I would like to ask Mr. Donoghue to respond to that.

Senator RUDMAN. I would like to know why, and think Senator Cohen would like to know why, because he has had hearings on this question probing this whole matter. We have a situation in the Federal Government now where one agency can find someone committing fraud and another one will continue to do business with them; same taxpayers are paying the same dollars.

I want to know why someone in the Department of Labor hasn't taken an active role to stop doing business with these crooks that are defrauding the Federal Government? I want you to tell me why? That is a simple question.

Mr. DONOGHUE. I can't answer for the Department of Labor, but I can speak to the legal question——

Senator RUDMAN. I am not interested in the legal question. I know the legal question. I want to know why the recommendation hasn't been made. I probably have as much experience handling that legal question as anyone in this room. I want to know why you haven't gone forth to adopt a regulation to do that?

Mr. DONOGHUE. Mr. Hartman indicated in his written statement that we are considering doing just that. The statute does provide for the free choice of physicians by the employee initially. It authorizes the Secretary, through Mr. Hartman's office, to monitor the treatment to insure it is proper, to monitor cases. The problem that comes down is there is no provision saying if someone overcharges that they should be disqualified or prohibited from representing employees or being the employees' physician.

Senator RUDMAN. That makes as much sense to me as the Air Force coming in and saying 100 airplanes crashed because they don't have fuel gages. Why don't you have fuel gages? Well, we considered it. I wonder whether you, sir, as counselor of this agency think it is a good practice to do business with providers who have been indicted and convicted on fraud against the Federal Government or any government or any private agency. Do you think that is a good practice?

Mr. DONOGHUE. Probably not.

Senator RUDMAN. How long do you think it is going to take, Mr. Hartman, to make a recommendation to the Secretary of Labor so we can at least get him up here and find out if he is going to adopt that recommendation?

Mr. HARTMAN. May I suggest, Senator, I quite agree with your statement, your concern. I share it and I am hopeful that the pending legislative package will permit the accomplishment of just what you are concerned with.

Senator RUDMAN. I don't think you need legislation. I think you probably need a regulation, but if you need legislation, I wonder how many Members of the Congress would dare vote against it. I would like to hear from you.

[At this point, Senator Roth entered the hearing room.]

Chairman ROTH. Would the Senator yield? I would like to ask the counsel, doesn't the Secretary have that authority now?

Mr. DONOGHUE. The Secretary has very broad regulatory authority.

Chairman ROTH. So he could make such a finding currently.

Mr. DONOGHUE. Yet when this issue came up, I did look into the Health and Human Services legislation, the medicare. They had very detailed statutory authority to review the bills and the treatment given to doctors under that program.

The review is conducted primarily by physicians in the given States or within the area. They also have due process protection afforded by law and by the regulations.

Under the FECA program, as you know, there is no judicial review, there is no adversary system.

Chairman ROTH. I would just like a simple answer. Do you think the Secretary has such authority under FECA to issue regulations that would prohibit continuation of providers who have been found guilty of fraud or abusive practices.

Mr. DONOGHUE. I am doubtful of that.

Senator RUDMAN. You are what?

Mr. DONOGHUE. Doubtful of that, that broad a prohibition of a doctor participating before the Department of Labor.

Chairman ROTH. Do you think he has that authority with respect to fraud?

Mr. DONOGHUE. I think he has a right to review ongoing medical treatment and care and where a doctor has been found improper treatment, then he could probably disqualify that person, but for actions not taken before him, I am not sure he could do that under present law.

Senator RUDMAN. If I understand his answer correctly for the record, he is now saying, the counsel to the agency, that it is his opinion that the Secretary of Labor doesn't have the authority—given a certificate of indictment or conviction given by a State's attorney or prose-

cutor—to say we will not do business with that person. Is that your answer?

Mr. DONOGHUE. Yes, sir.

Senator RUDMAN. I have two more quick questions, Mr. Chairman. Mr. Hartman, in the course of your oral statement, you said, "we need to develop a reporting system." Are you telling us that as of right now you don't have a reporting system in place to prevent the situation we heard about yesterday where a patient received stitches and injections for the same wound several hundred times?

You don't have a system that would catch that in place at this time?

Mr. HARTMAN. We clearly have a system for that. My reference with respect to the reporting system was to an exchange of information between agencies.

Whatever it may be, there is no formal reporting system at this point for the exchange of information.

Senator RUDMAN. And my final question, Mr. Hartman. We have to leave for a vote, and unfortunately I can't return to the hearing. I want to ask you this: Do you think it might be good in a pilot program to do what we are doing with debt collection? What do you think of taking one agency of the Federal Government and giving that to a private carrier for administering that program, and at the end of the 2 years, looking at the cost-effectiveness of that particular program compared with what you are doing in that office? Do you think that is something we might want to do?

Mr. HARTMAN. I think it is sound and should receive consideration.

Senator RUDMAN. Because you know, Mr. Hartman, I don't have any idea other than that you are a sound, well-motivated person, as is, I am sure, your staff. The fact is this may be too big for anybody. It seems you have been butting your heads against the wall since 1978 without getting any where. Maybe we ought to break it up a little bit.

Mr. HARTMAN. A group of employers, as the agencies are, employing 3 million, that is a substantial insurance risk.

Senator RUDMAN. You don't disagree that maybe we should have a pilot program in the private sector to see if we can come out with a few dollars for the taxpayer?

Mr. HARTMAN. I do not.

Senator RUDMAN. Thank you.

[At this point, Senator Roth withdrew from the hearing room.]

Senator COHEN [presiding]. I have a couple of observations, rather than questions. Mr. Hartman, you impress me with your sincerity in coming before the subcommittee and outlining the problem. I hope you can get a sense of the frustration that many members feel because we have also had hearings on home health care.

We found, I think, a very valuable program being rather easily abused, with almost no controls, and no checks in a system which could, in fact, be defeated or die because of parasites who grab onto that particular program and kill it. It seems to me that applies there. We have had hearings dealing with contractors who have been debarred by one agency who then walk across the street and do business with another agency. We have had physicians convicted of fraud who can still participate in Federal programs.

I think what struck me about your testimony is the sincerity of it. This system seems out of control. How do we shock people into saying that the gravy train doesn't stop here any more? What is it that we do to change the whole attitude? One of the prior witnesses said there really isn't much incentive to go back to work if you can get two-thirds of your pay untaxed and stay on compensation in that fashion. What incentive is there to go back to work and say "I have got to get a job," or as you put it, "I have to get back to work?"

What we are doing with our current system? What was it you said? Our testimony is we have got a hell of a problem but there is no sense of immediacy involved, there is no sense of real urgency that we have to do something quickly. A witness who will testify following this panel will indicate no radical changes are needed in the FECA law. But I don't see any real sense of emergency and I don't see any incentives under the current system to save money because there is this attitude of, "look, I am not paying for it."

For instance, we file a claim, we followthrough the process, it can be abused but somebody else is paying. There is nobody within the Federal bureaucracy that has a real incentive from preventing that from taking place. You can have well-motivated people, like myself, coming in from the outside and saying, my God, it is massive. We have millions of people involved here, how many claims did you say were filed?

Mr. HARTMAN. 220,000.

Senator COHEN. How do we have a handle on that? We have 3 minutes. Here comes another part of the problem. There is a notion somehow in the bureaucracy, the problem will go away because the Senators are off voting on the tax bill at 12:20 and from there they will go on to a meeting on armed services or another meeting. So time seems to be the enemy of any kind of real Government scrutiny. And the system goes on and on with very little being done effectively to at least discourage this kind of abuse.

So I appreciate your sincerity and your, I think, openness coming before us.

You have a hell of a problem. What we have to do is find out what we can do legislatively. If it takes a legislative mandate to tell the Secretary of Labor that "we are going to give you the power to issue regulations saying any physician convicted of fraud cannot do business with the Federal Government any more," then we will do that. We will have it out of this subcommittee next week, if that is what it takes.

Mr. HARTMAN. Highly desirable, Senator, thank you.

Senator COHEN. What we are trying to convey is a sense of immediacy, that something has to be done.

Mr. HARTMAN. My written statement conveyed the thought; if not, I trust my oral statement did. Let me say now that I personally sense deeply and sincerely the need for action and the need to get the agencies more directly involved in the welfare of their employees, the good and the bad.

Senator COHEN. I thank you all for your testimony. I am going to have conclude this and run off to vote. But I can reassure you we are going to be coming back time and time again to keep your eyes on

this particular problem. The subcommittee will stand in recess for 10 minutes.

[Brief recess.]

[Members of the subcommittee present at the time of recess: Senators Cohen and Rudman.]

[The letter of authority follows:]

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
Washington, D.C.

Pursuant to Rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the Chairman, or any member of the Subcommittee as designated by the Chairman, to conduct open and/or executive hearings without a quorum of two members for the administration of oaths and taking testimony in connection with hearings on fraud and abuse involving the Federal Workers' Compensation Program on Wednesday, July 22, 1981, and Thursday, July 23, 1981.

W. V. ROTH, Jr.
Chairman.
SAM NUNN,
Ranking Minority Member.

[Member present after the taking of a brief recess: Senator Roth.]

Chairman ROTH [presiding]. The subcommittee will please be in order.

I will not ask the prior panel to return, but I will advise them that we expect to have additional questions which we will submit in writing and ask for them to be answered within 7 days.[1]

Mr. HARTMAN. We will be pleased to do so, Senator. Thank you.

Chairman ROTH. Mr. Hartman, I also want to state, as I have on several occasions, that we are going to be extremely interested in what followthrough steps are taken to correct the situation in this program, and by what steps, I mean what you are actually doing. I think the time has come where we no longer can afford pilot studies, investigations and further study.

The time has come for action. I intend to write people in the Department of Labor and elsewhere, including OMB, to insure there is followthrough and I will put you on notice that we will hold hearings at least within 6 months to a year.

Mr. HARTMAN. I appreciate that and I trust we will be in a better posture than we are today.

Chairman ROTH. Thank you.

Mr. Blaylock and his party, please.

Please rise and raise your right hand. Do you solemnly swear to tell the truth, the whole truth and nothing but the truth, so help you God?

Mr. BLAYLOCK. I do.

Mr. VANN. I do.

Ms. PARKER. I do.

Chairman ROTH. Mr. Blaylock, I would appreciate it if you would introduce those accompanying you and then proceed with your statement.

[1] See page 146–230 for questions submitted by Senator Roth to Mr. Donovan and answers thereto.

TESTIMONY OF KENNETH BLAYLOCK, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, ACCOMPANIED BY TOLLIE VANN, JR., EMPLOYEE RELATIONS SPECIALIST; KIMBERLY C. PARKER, LEGISLATIVE REPRESENTATIVE

Mr. BLAYLOCK. Mr. Chairman, on my left is Kimberly Parker, who is legislative representative for the American Federation of Government Employees. On my right, Mr. Tollie Vann, who is the compensation specialist for my organization and for at least my 5 years while national president has handled the workmen's compensation problems for my organization and its members.

I would like to enter my written statement for the record, Mr. Chairman, and will not read it but I will refer to a few passages in that statement, and I would like today to just give you the employee's view of the program and our experiences with it over the last several years.[1]

We do appreciate, first off, the fact that your subcommittee is holding hearings on a very important issue to a lot of Federal workers. And we have appeared before congressional committee before and raised many of the issues that I heard raised by members of the subcommittee this morning, and in listening to the two previous panels and comments made by the subcommittee members, I would say that we are not in disagreement with any comment made by the subcommittee.

I would also like to initially point out that the workers themselves are totally opposed to graft, ripoffs, and kickbacks that are definitely involved in the program and in your investigations you have run into a few of those. It is our opinion, and we testified in 1977 that the program was administratively bankrupt and, as of today, we haven't seen any improvement.

My union, in 1978, went before the Congress, not criticizing so much OWCP, but taking the position they did not have adequate resources and manpower to do the job and as a result of that, along with the Department of Labor presentations, Congress did authorize, by the way, in 1978, about 800 additional positions.

I am sorry to say we haven't seen much improvement as a result of getting additional manpower.

We see the program basically, Mr. Chairman, as a very poorly administered program that seems to allow those who really are not qualified to very easily get benefits under the plan and for those who have dire need of the benefit, and that is where Mr. Vann gets involved with our organization, it sometimes takes as much as 2 and 3 and 4 years to get compensation going and we have seen families become destitute because of inadequate administrative procedures within the program.

That, of course, is one of our major concerns. We do not support the medical community abusing the program and we do not support employees abusing the program. We think the critical point in the program is when the initial determination is made as to whether the employee should or should not get the benefits.

We supported the 45-day continuation of pay. We supported that because it took so long to get the benefits started and families do have to survive. My union does not support the idea of workers who really

[1] See p. 143 for the prepared statement of Mr. Blaylock.

do not have job-related injuries being able to sponge off the program. On the other hand, when an employee does have a job-related injury, then the basic principle of this country is the employer has an obligation to take care of that employee and employee's family.

We think preventive maintenance is an area that needs to be looked at very seriously. As you well know, the Occupational Safety and Health Act was never extended to the Federal sector. If the amount of money being spent in compensation to injured employees had been spent in safety programs in Federal activities, these figures you are dealing with today would be a lot less and the private sector has proven that. Yet we have resistance by the agencies and by the Congress to impose those kinds of safety standards to the Federal work set.

That is part of your problem.

Another very serious part of your problem is the agencies themselves use the workmen's compensation program as a personnel tool, and by that I mean we have witnessed many times situations where the judgment as to the qualification of the employee seems to be based more on the personnel program of the agency, on the personalities that exist and the relationships between the employees and the managers. I think there is a critical area there.

You know, you people budget money for these agencies every year, this so-called chargeback to the agency from OWCP to the agency for the moneys paid, incurred in the workmen's compensation program, but several years ago that became a line item in the budget so it really doesn't cost the agency anything. It is line item every year. They are budgeted and given the *x* million dollars they need.

It doesn't come out of their hide. One, why should they worry about a safety program and, two, why should they worry that a person is on the program? If you will investigate, you will not find one agency today that really has a rehabilitation program to get workers back to work and there are many times people are injured and they are not able to do the normal job they were doing but there are many types of jobs they can do and it is job training to rehabilitate them that paid off in the private sector.

We heard a lot today about what the private sector does and what we do. If we take a few examples out there in the area of safety and rehabilitation and in the area of program controls, I think we have got managers that are probably as intelligent as the managers in the private sector, but it really doesn't matter to an agency.

The different types of situation you see at the worksite, one if you have an employee who is not necessarily—we will say doesn't have a real friendly relationship with supervisors, well, it is very easy to get the paperwork filled out so that individual qualifies and that gets him or her out of their hair.

Or if we have one who maybe is real friendly and he is good old Charlie. Charlie has been around for a while, Charlie wants to get outside and get a little side something going, then it is not too difficult. Or you may have the other situation where they don't particularly like Joe and Joe really got hurt on the job, but it is very difficult for Joe to get the substantiating documentation, what have you, to qualify, so personalities play a role. Preexisting conditions, agencies really don't care. The in-hire practice of an agency could eliminate an awful lot of that program. I agree totally with the comments made by Senator Cohen earlier. The program is not designed to pay people for injuries they incur before they come to work on the job.

It bothers us because as we have said before other committees: Sooner or later the abuses of the program are going to cause just exactly what is happening today and the program is going to be cut back; not necessarily made better, but it is going to be curtailed to the point that people who are honestly entitled to it are not going to have it.

We heard the rhetoric before about the size of the program, the tremendous workload and what a big job it is. But, Mr. Chairman, the claims that run for the last 10 years are an average of around 30,000 claims a year. When you really look at that, that is not that big a program. To start with, they had a centralized program, everything floated up to the central office. That is part of the problem. Their computer system today still is not working. Then they have certain decisions that were lowered down to the regional level. We were advocating decentralization all along in the program.

The critical point in the program is when the decision has to be made did the person get hurt, did they not get hurt, are they entitled or not entitled? That should be done in the area and it could be done with a panel of medically qualified people to make that determination.

You have two determinations to make. One, was he actually injured in the performance of his work? The agency and whatever administrative panel person needed to make that decision could make that very easily. Second, what is the extent of his injury? Therefore, he is entitled to medical treatment, entitled to compensation, or he isn't. Ninety percent of the cases could be made right there in the area where the situation occurs. If you have more than one doctor, we will say two or three medical types right there and are all in agreement, then you can go ahead and process that as a rapid process system, which we advocated for 4 years, by the way, and it would never float into the system and clog it up.

If there are disagreements—ones on appeal—send it to the regional level and some type of review be made there. It seems pretty simple to us. When we look at the complicated processes that are being used by the OWCP to process, we don't see it that much as a complicated problem. Of course, maybe it doesn't generate as many high positions up here in the silly city we all live in, but it would surely solve the problem at the level the problem occurs.

That is where we are at and that is basically where we are going to be in the program.

I would like, Mr. Chairman, to just wind up my comments by, again, reciting some of the recommendations we have made in the past.

First, we think the Department of Labor should be required at one or more district offices to set up a pilot program and test the practicality of a system of rapid processing of claims based on second medical opinions and by the OWCP physicians.

Second, the Department of Labor should issue regulations prohibiting payments of OWCP to physicians who have been found to have committed fraud in government programs: medicare, medicaid, and even this program.

It seems atrocious to me that a Federal agency will say we really can't do that. Fraud occurs in a lot of ways out there, by the way. You

know and I know, I can go to my family physician and I can get him to give me a statement and just about anything I want.

Then if I go to another physician, professional ethics being what they are, you are never going to get one to give you a direct statement to say the first doctor was wrong.

That is the reason we feel there should be a joint review of the application by two or more physicians at the same time. Don't put them in the position of me going over here, get my doctor and later another doctor having to say he was right or he was wrong.

We think that could be set up very easily out there in the local areas. The Department of Labor should develop fee schedules for individuals executed for the regional offices to determine whether the medical or hospital charges are reasonable. We do it in our health benefit programs in the Federal sector.

All of the carrier plans use a reasonable fee basis for payment of health benefits and we see no reason why it couldn't be done in this program. The Federal agency should immediately implement a retraining and replacement program for FECA beneficiaries who are able to return to another job.

It is possible some sort of incentive system could even be developed. The main thing is most agencies, once the person goes on workmen's compensation, then they go ahead and fill that vacancy and they don't want the person back.

There is really no effort to retrain or no effort to bring back and that gets into the personnel program of the agency. You run into a little problem here and it is going to take some legislation to help resolve it. You have this dynamic and there is some legal background to it, a lot of it is turf, where one agency will not dictate to another agency and you are very familiar with that.

That is part of the problem, because we have sat with the past Secretary of Labor and talked with these problems; we sat with the Directors of OMB and talked about these problems and the FACOSH meetings we talked about these kinds of problems and they are very reluctant to tell another secretary of another agency you have got to do this.

So I think it is going to take some congressional intervention before that problem is resolved because in reality, OWCP will not be able to move into Army or Air Force, Navy, any of the other agencies unless they get some authorities from Congress. So you should think about that.

The patient and the physician should both be required to sign a form validating the diagnosis and the recommended course of treatment. This business of doctors submitting statements saying they have treated a guy 22 times for the same illness, I would suspect that if that individual had to sign that voucher, a lot of them probably wouldn't sign that voucher.

We think there are some very simple corrective actions that can be taken to administratively get the program back on track. And we simply are asking the Congress, don't throw the baby out with the bath water because you do not have a lot of people out there who do get injured on the job and should be taken care of in one form or another, and to just reduce their benefits is not going to resolve the problem.

Again, Mr. Chairman, I would like to thank you very much for giving us the opportunity to give you the workers' view of the program.

Chairman ROTH. Mr. Blaylock, I would like to express my appreciation to you for coming here today. Finding that we are in substantial agreement as to things that need to be done, I want to underscore, again, that I for one feel that those employees who are injured on the job are entitled to be taken care of and to be taken care of promptly.

That is the purpose of the program, as I understand it and as I think it should be. I am concerned, however, that because of those few, both within Government and outside, that are taking advantage of it, it does create an environment where the innocent victims are really the other Federal employees and the taxpayer.

So I applaud your coming here. I must confess, as I listen to you enumerating a number of things that should be done, that I find I am totally mystified as to why these aren't obvious or if there are better alternatives why they haven't been found by those responsible for its administration.

I agree with you that providers who have defrauded, or have submitted improper claims should not be utilized further. Otherwise, you have an open invitation to people to defraud the Government.

I also agree with you that we ought to have some kind of fee schedule. As I say, it appears to me that no progress of any substantial type has been made from 1978, when Secretary Marshall asserted, and I think properly so, that steps were going to be taken to clean up the administration of this program.

Is the Department of Labor still unresponsive to employee claims, or are you satisfied with the speed with which they are being handled?

Mr. BLAYLOCK. Mr. Chairman, I would agree with the first statement you made; we see very little improvement, and I guess it is somewhat spotty. In certain areas of the country, we have seen some improvement in those offices, but in the general sense, if you look at the backlogs that are generated each year and the backlogs they have been carrying and the time frames involved, we do not see that much improvement.

Chairman ROTH. And as I understand your testimony, there has been additional personnel secured and yet no improvement.

Mr. BLAYLOCK. In 1978, Congress authorized, I think it was 884, additional positions for this program and most of those positions were filled.

But, again, we have seen very little improvement as a result of that. The comment I made to start with, Mr. Chairman, administratively somebody just doesn't seem to have the ability to determine where that Department or where that program is going and what it is going to be doing and how it is going to be doing it.

I think the people themselves are totally capable of doing the job but there is some direction needed very bad.

Chairman ROTH. I agree with that. I think we need administrators that know what needs to be done. Mr. Hartman did testify that he had some difficulties securing them. He ought to insure we get those that are necessary to do the job.

I have no further questions, except I do have one request that you have heard me say earlier. We intend to continue from time to time to monitor this particular program with the goal of securing adequate checks and safeguards to make the program effective from the standpoint both of the worker and from the point of view of the taxpayer.

I would appreciate, as the months roll along, that you keep in contact and advise us as to what progress, if any, you think is being made.

Mr. BLAYLOCK. We look forward to working with you, Mr. Chairman.

Chairman ROTH. Thank you.

Before summarizing the last 2 days of testimony, I want to thank all the witnesses for appearing before us.

Turning to the evidence presented, I think we can all agree that the purpose of this hearing, to demonstrate the susceptibility of the program to fraud and abuse, has been achieved. We have seen that medical service providers, some Federal employees, and even a corrupt Department of Labor program employee have manipulated the system to their own benefit.

I think it is particularly obvious that we have seen that the internal mechanisms created by the Department of Labor to manage the program are totally inadequate and very, very slow.

Frankly, we have also seen that few efforts have been made by Department of Labor officials to identify the fraudulent and abusive practices which undermine the basic purpose of workmens' compensation to swiftly and fairly aid those truly disabled on the job.

Even when medical service providers have been identified to the Department of Labor, the responsible officials have been unable or unwilling to adequately protect the expenditure of public funds. These same officials have also failed to address the basic concept of medical cost containment, which has been mandated by the Federal Government on other Federal and State medical assistance programs.

These observations clearly require the Congress and the Department of Labor to reassess certain priorities in the management of the Federal workers' compensation program. Consideration, vast consideration, must be given to the creation of a satisfactory system to allow the Federal Government to protect the public funds which are being paid out as compensation benefits, from being needlessly squandered.

In this regard, we have heard a number of sound recommendations which have enabled the Department of Labor to effectively address the weaknesses in the current system.

First, State and Federal agencies, such as law enforcement organizations, and the Health Care Financing Administration, are already engaged in the identification of fraudulent and abusive medical practitioners.

This identification information should be disseminated to all Federal programs which may involve such practitioners.

Second, once such practitioners have been identified, it has been recommended that the Department of Labor must have an appropriate administrative mechanism to eliminate those practitioners from participation in the Federal workers' compensation program.

Such an exclusion or debarment is a well-established remedy in a variety of Federal programs. We have heard testimony concerning the

operation of just such a remedy which is available to exclude fraudulent practitioners under the medicare-medicaid programs.

Furthermore, I would like to point out that my colleague and fellow subcommittee member, Senator Cohen, in his capacity as the chairman of the Governmental Affairs Subcommittee on Oversight of Government Management, has recently issued a report concerning the Federal suspension and debarment process.

This process is created by regulation to identify and exclude fraudulent contractors from participating in Federal procurement. The report recommends that in the procurement system, the administrative debarment of a contractor by one Federal agency would be binding on all other Federal agencies.

Consideration should be given to the creation of a similar exclusion policy which would operate between medicare-medicaid and Federal workers' compensation.

I might also say, I will request the subcommittee look into the authority of the Secretary of Labor to issue regulations in the area of debarment.

Third, it has been recommended that the Department of Labor should immediately adopt efforts to implement medical cost containment in the payment of medical benefits. Such cost-saving mechanisms are already in place in the medicare and medicaid programs.

Finally, it has been urged that the Department of Labor must increase its efforts to improve the claims adjudication process. Claims must be given more careful scrutiny from the outset to insure that benefits are provided only to those who are truly eligible.

We have heard repeated testimony of poor administrative practices which result in the payment of millions of dollars in benefits to ineligible claimants.

In closing, I will say the subcommittee will give careful consideration to each of these recommendations. We will prepare a report and consider if legislative changes are necessary in the program.

Finally, we will continue to monitor the activities of the Department of Labor in administratively addressing the concerns which have been expressed at the hearing.

I firmly believe that through the cooperative efforts of the legislative and executive branches of the Government, the weaknesses in the Federal workers' compensation program can be corrected to the benefit of those they cover.

I want to enter into the record two news stories [1] and Dr. Josephs' attorney letter [2] that was referred to yesterday.

Chairman ROTH. We will be keeping the record open temporarily for receipt of additional evidence.

[Whereupon, at 1:02 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

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[1] See pp. 231–233 for newsstories submitted by Senator Roth.
[2] See p. 230 for letter from Dr. Josephs' attorney.

APPENDIX

I. Prepared Statement of Senator William S. Cohen

Mr. Chairman, I want to commend you for initiating these hearings on fraud and abuse in the Federal workers' compensation program.

These hearings are consistent with the pledge you made at the beginning of the 97th Congress to use this forum to investigate, expose, and eliminate instances of waste, fraud, and abuse in Federal programs. Accordingly, at both full committee and subcommittee levels thus far this year, we have examined waste, fraud, and abuse in the Federal Government in general, as well as in particular programs, such as the home health care operations administered by the Department of Health and Human Services.

There can be a great deal of positive fallout when we paint with a broad brush to expose waste, fraud, and abuse in numerous Federal activities. In particular, we can discover that patterns of problems tend to emerge.

There is one pattern which is of particular interest to me. It concerns whether or not we effectively suspend or debar those "actors"—whether they be individuals or corporations—who do not live up to their obligations to perform satisfactorily and ethically when providing a service either to or for the Federal Government.

For example, we saw in hearings in May before this subcommittee that a home health care provider which has defaulted on services often does not need to worry about being suspended or debarred. Instead, it can merely reconstitute itself into another entity with a new company name but with the same management. This new company can then continue to either provide no services or inflate the costs of the services which it does provide—and the taxpayer, in the end, bears all of the costs.

We saw this pattern again in hearings in March before the Subcommittee on Oversight of Government Management. There we saw that a contractor who has been suspended by one agency for suspected fraud or poor performance can simply walk across the street and commence doing business with another Federal agency. Suspensions and debarments are not now binding Governmentwide.

And now we will see in these hearings that, if a physician defrauds the Government—and is convicted of that fraud—the Department of Labor will only exclude or debar that physician from participating in the Federal workers' compensation program on one general condition. The condition is that the physician must lose his license to practice medicine. But the kicker here is that a fraud conviction rarely results in the revocation of a physician's license.

So the upshot of all this is that a physician who is convicted of fraud against the Government can continue to provide more services—or, more accurately, can continue to pretend to provide services—and then continue to be paid for those services by you and me.

In 1980, the Federal Government paid $670 million in compensation benefits and $110 million in medical benefits under the Federal workers' compensation program. Those are a lot of benefits. But there should be no room, in a program with those benefits, for people who have defrauded the Government.

So, Mr. Chairman, I think that you provide an invaluable service when you provide this forum and this opportunity for us to examine the causes of—and the cures for—those instances of fraud which have crept into the program which we'll be examining today.

I welcome the opportunity to participate in these hearings.

II. Prepared Statement of Howard W. Cox, Staff Counsel, and Karen A. Hainer, Investigator, Senate Permanent Subcommittee on Investigations

Mr. Chairman and members of the subcommittee, in March of 1981, the Permanent Subcommittee on Investigations (PSI) began an in-depth examination of Federal workers' compensation—an $800 million a year benefits program which our preliminary review indicated is easily abused and precariously exposed to fraud and waste. After launching an investigation we conducted on-site interviews, in several geographic locations, of key participants and made a thorough review of the administration as well as the legislative history of this program.

Before turning to a detailed discussion of our investigative work we will first briefly outline basic features of the Federal workers' compensation program. This outline provides a framework for our analysis of some program aspects, and it also serves to introduce the testimony of others who will address different facets of the program later in the hearing.

OPERATION OF THE FEDERAL EMPLOYEES' COMPENSATION PROGRAM

Since the turn of the century, workers injured on the job have been able to obtain compensation from their employers through administrative rather than legal procedures. Workers employed by the Federal Government come under the compensation entitlement provisions of the Federal Employees' Compensation Act (FECA). Administrative responsibility for the program was assigned to the Department of Labor (DOL) in 1950 and remains with DOL's office of workers' compensation programs (OWCP) today. Financing of the program is through funds appropriated by Congress directly or indirectly in a charge-back to Federal agencies. Agencies include the designated amount of the charge-back in their budget requests, and the resulting sums appropriated are then deposited in the employees' compensation fund.

Disability coverage under the program includes wage loss compensation, medical care, and survivors' benefits provisions. Since 1974, a disabled worker's full salary continues for the first 45 days lost from work. This continuation-of-pay expense is borne directly by the employing agency. Direct DOL payment for a work-related disability begins after the initial 45-day period. Compensation payment is calculated at 66⅔ percent of the employee's salary, tax free, for the period of disability. Compensation increases to 75 percent, tax free, if the employee has dependents. Loss of bodily part or function entitles a worker to an additional set schedule award. If an employee remains disabled beyond age 65, there is no conversion of disability compensation to a retirement annuity; full disability payment continues.

DOL is principally responsible for determining whether a traumatic injury or occupational disease is causally related to the employee's work, or whether a pre-existing injury or illness was aggravated as a result of employment. If a claim is judged valid, DOL determines degree of disability—permanent or temporary, total or partial—and provides the mechanism for automatic benefit payments. The Government is liable for all "reasonable" medical costs with no time or monetary limitations imposed on medical care as long as there is a "substantiated" need for continued treatment. Reimbursement for medical services is made directly to the provider. Federal workers have the right to seek treatment from a "qualified" physician of their own choosing. Additionally, vocational rehabilitation with reemployment as the ultimate objective is another steward responsibility of DOL.

Over the past years, congressional committees and the General Accounting Office (GAO) have pointed to administrative and legislative shortcomings of this program. The GAO, since 1976, has concentrated on the timeliness of claims adjudication, DOL criteria for determining compensability, and the periodic monitoring of disabled Federal employees. Representatives of the GAO will be discussing their past analytical work on the compensation program later today. While other reviewers of the program have alluded to insufficient safeguards to protect against false or misleading claims, no attention has been devoted to the area of payments to medical providers. The paucity of investigative work coupled with the skyrocketing amounts paid to medical providers—up from $31,730,000 in 1973 to $109 million in 1980—led us to conclude that this was an appropriate area for scrutiny.

Let us emphasize here that it was not our objective to question or undermine the legislative intent of the Federal workers' compensation program. We did

not set out to dispute the Government's responsibility to its employees for work-related injuries. Rather, we became concerned that those for whom benefits were not intended are inordinately profiting from workers' compensation. At all times it was our primary purpose to strictly assess the vulnerability of this program to fraud, waste, and abuse.

PSI INVESTIGATION: MEDICAL PROVIDER FRAUD

Increasingly, physicians and other medical providers have been found to have engaged in insurance related fraud schemes. These schemes extend to several types of insurance: Automobile accident, medicare, medicaid, and State as well as private workers' compensation. State and Federal law enforcement agencies investigate such schemes, particularly the U.S. Postal Inspection Service since the U.S. mail is frequently used in the fraud.

Just recently in Washington, D.C., for example, Dr. Thomas M. Dent, III, pleaded guilty to one count of mail fraud and one count of filing a false claim to the Federal Government. First investigated for an alleged scheme against private insurers in which he sold false and inflated medical reports, Mr. Dent was subsequently tied to a false worker's compensation claim filed on behalf of a Federal worker with DOL.

At about the same time that we learned of Dr. Dent's conviction, we were informed by the Postal Inspection Service of a 96-count indictment in New York City against Dr. Richard Kones. The Federal grand jury charged Dr. Kones with perpetrating an extensive insurance and mail fraud scheme for which he realized $2 million in false claims. One-third of the counts against Dr. Kones involved Federal workers' compensation fraud. Dr. Kones allegedly billed DOL over $123,000 for treating one Federal worker who sustained two on-the-job injuries between 1975 and 1979. [See Exhibit 2] While this worker lost less than 5 weeks of work time as a result of both injuries, according to the bills allegedly submitted by Dr. Kones, the worker received highly extensive, expensive medical care two or three times each week over a period of many months. Dr. Kones has been convicted of medicare fraud—in 1974 in New York—and medicaid fraud—in December 1980 in Connecticut—he is currently under indictment in Westchester County (N.Y.) on 22 counts of filing false claims with his own disability carrier, and in Houston (Tex.) for kiting $75,000 in checks; finally, Dr. Kones is presently being sued by the Federal Government for return of $500,000 with respect to the workers' compensation fraud.

As we delved into the Drs. Dent and Kones cases, we began to realize that fraud schemes against private insurers could easily be carried over to the Federal Government's disability coverage program. Transference of the fraud schemes from private to government sectors can not simply be attributed to the sophistication of these schemes. Rather, we soon learned that DOL claims oversight and bill payment procedures are void of the checks and balances needed to insulate against abuse. Why, for example, were no questions asked about a physician who billed for intricate cardiac treatments supposedly rendered, which totaled thousands of dollars, when it was known from the claims file that the Federal worker lost minimal time from work and received no disability benefits himself? The answer, we were told, had to do with the fact that these medical bills were authorized and paid by GS–2 bill paying clerks, not higher ranking claims examiners. And, we were assured, the Dr. Kones case was an aberration.

Working on our theory that doctors who have engaged in one type of claims fraud probably carry over their questionable practices to Federal workers' compensation claims, we asked the Postal Inspection Service to identify providers recently convicted of Federal mail fraud offenses related to insurance schemes. Of those identified, we decided to look at Dr. Allen Josephs, convicted in New York in April 1981 of private insurance-related mail fraud. At the beginning of our investigation, we were unaware that Dr. Josephs had ever submitted to DOL any medical bills on behalf of Federal workers.

The background information we gathered on Dr. Josephs, who practices in East Northport, N.Y., indicated that he had been tried and acquitted in 1977 on medicaid fraud charges in Suffolk County, N.Y. Before his trial, Dr. Josephs voluntarily agreed to repay the county $8,000 and to be permanently barred from accepting medicaid patients anywhere in the State. Later, in 1977, Blue Cross/Blue Shield of greater New York asked the Postal Inspection Service to investigate Dr. Josephs for repeated billing for treatments which were never rendered. According to the insurance carrier, it was first thought that Dr. Josephs spe-

cialized in family abuse cases—medical reports he filed showed that members of several families suffered an unusual number of traumatic injuries every third day over many months. The investigation concluded that most of these treatments were fictitious. Dr. Josephs was indicted, pleaded guilty, and sentenced earlier this year to serve a year and 1 day in Federal prison. Dr. Josephs is currently incarcerated.

We attempted to find out whether Dr. Josephs treated any Federal workers who sustained on-the-job injuries, and if so, how much he had been paid by DOL. The Department assured us at the outset of our inquiry that this information could be retrieved at the touch of a computer button. Twenty claimant files in which Dr. Josephs was the treating physician were initially identified for us. We reviewed each of these files at DOL's New York district office. Assisting us were two GAO auditors, one of whom has examined the compensation program over the past 6 years for GAO.

Patterns were quite easily identified from our file reviews:

Federal workers treated by Dr. Josephs sustained relatively minor injuries—back strains, sprained wrists, lacerations—but were allegedly treated for extensive periods.

Most of the workers returned to work within weeks after their injury. Few received compensation benefits from DOL. Yet all of the claimants supposedly required medical treatment on a twice weekly basis for months or years.

Treatments were seemingly inexpensive—Dr. Josephs typically billed for $12.84 examinations and $4.90 injections.

Each claimant received similar treatment from Dr. Josephs—an examination, heat treatments, and injections of pain killers or muscle relaxants.

Usually, workers were allegedly treated every Monday and Friday, week after week, month after month.

All totaled, it appeared that Dr. Josephs was paid over $50,000 for repetitive treatments which bore a strong resemblance to the false Blue Cross services which were the basis for his criminal conviction. On-site interviews with more than half of the Federal workers whose files we reviewed substantiated our preliminary findings that Dr. Josephs systematically overcharged DOL. In two instances, our interviews with claimants established that Dr. Josephs continued to bill DOL for twice weekly visits more than 1 year after these workers ceased visiting the doctor. In at least three other instances we established that Dr. Josephs billed DOL for visits which were never made and for treatments such as injections, prescription drugs, and diathermy which were never rendered. [See Exhibit 3]

Typical of the cases we examined are the three Federal workers who will testify today. While each of these witnesses can better discuss their individual work-related injuries, compensation claims, and treatment received from Dr. Josephs, let us summarize the information we found in their DOL files.

Richard Giannino.—According to Richard Giannino's injury compensation file, his knee, which he lacerated on June 10, 1976, was stitched and restitched week after week for almost 4 years. That's a total of 284 office visits, twice a week, and each time Dr. Josephs reported to DOL that he placed sutures in Mr. Giannino's wound. Our review of this file also indicated that Mr. Giannino supposedly received injections on a regular once-per-week basis. Most of this medical care was rendered, according to the file, long after the claimant resumed his work as a mail carrier. [See Exhibit 4]

Lois Ryan.—A review of Ms. Ryan's DOL file shows that she was treated from December 1978, when she strained her back at work, until April 1980. Medical reports and bills submitted by Dr. Josephs claim that Ms. Ryan was examined 140 times, that she was x-rayed and her back was strapped with adhesive tape 140 times, and that she received 140 muscle relaxant injections. Here again, Ms. Ryan's file indicates that she returned to work several weeks after her injury. She never received compensation benefits from DOL nor did she ever report any recurrences of her back injury. From the period January through August 1979, Ms. Ryan's file also indicates that she filled and refilled a controlled substance prescription at Tick Tock Drugs. This did not surprise us as most of the files we reviewed showed that Dr. Josephs frequently prescribed muscle relaxants and pain killers. Often, claimants filled their prescriptions at Tick Tock Drugs, located at East Northport, N.Y. Tick Tock Drugs billed DOL directly. [See Exhibit 5]

Hector Monthalvo.—Dr. Josephs billed DOL for treating Hector Monthalvo 281 times from early 1978 through April 10, 1981. Reconstructing Mr. Monthalvo's treatment from his medical records indicates that his sprained elbow was supposedly examined and strapped with adhesive, and that he was given an injection twice weekly, every week, over 3 years. Mr. Monthalvo, too, returned to work several weeks after his accident. There is no indication in his DOL file that the condition for which he allegedly required continued medical treatment interfered with his work as a vehicle repairer. [See Exhibit 6]

These billings, in each of the three cases, were all submitted without the knowledge of the claimant. At no time did DOL check to see if these workers were receiving medical care.

Dr. Josephs was invited to speak with us but he declined to do so through his attorney.

It would be inaccurate to assume that medical providers and others must devise complex schemes to defraud DOL. Rather, it is the compensation program which is devoid of basic internal controls to guard against user abuse and manipulation.

MANAGEMENT OF THE DOL WORKERS' COMPENSATION PROGRAM

Each of the claimant files that we reviewed in the Dr. Josephs case contained "red flags" which should have alerted DOL staff. Early warning signals were also present in many of the claims files reviewed by PSI staff in New York, Boston, and the Hearings and Review (Washington, D.C.) branch offices.

Sloppy documentation—of causality and disability—was common to the claimant files we examined. Files of claimants treated by Dr. Josephs, for example, contained the barest of probative medical evidence. We never saw reference to the worker's medical history in the Josephs' files. The doctor's diagnosis was always cryptic, always limited to a one-line comment which included reference to a strain, sprain, or spasm. Progress reports were equally brief and usually submitted on a New York State Workers' Compensation Board checkoff form, rather than DOL's own forms or medical provider letterhead. And the progress reports submitted by Dr. Josephs repeat, down to the last word, the previously submitted reports. Thus, in the cases of Ms. Ryan and Messrs. Giannino and Monthalvo, each of their files contains a one-line medical report which had been submitted and resubmitted over a period of years.

Repetitious medical bills never provoked closer examination by DOL staff. Dr. Josephs, for example, consistently billed for examinations, heat treatments, and injections at artificially low amounts. When his bills are added together, however, the profitability of such a scheme is obvious.

If the DOL bill payment system cannot identify medical providers who nickel and dime the program, it certainly does not capture the provider who submits repetitious bills for more sophisticated-sounding medical treatment at higher rates. Returning to the payment history of Dr. Richard Kones, the New York physician currently under indictment for over $100,000 worth of Federal workers' compensation fraud, we saw that his alleged treatments averaged $500–$600 per visit. On one day, he was twice sent checks for over $5,000 by DOL bill paying clerks. And this was reimbursement for alleged treatment rendered to one worker. No questions were asked as Dr. Kones billed DOL one sum—$632.00—82 times over the course of several months. Again we found that the fault lies in DOL's bill payment process.

One of the few monitoring controls DOL contends it maintains is approving a claimant's switch from one physician to another. Employees are entitled to the choice of one physician, but any change must be approved by DOL. We noticed that several of the claimants treated by Dr. Josephs had been seen initially by another physician. However, not one of these files contained the necessary DOL approval forms authorizing a change in physicians to Dr. Josephs. When Dr. Josephs billed for his services in these cases, he was paid without question.

Many of the cases we examined were ones in which the Federal workers lost no more than 45 days from work due to the injury or work-related illness. These cases are initially accepted by a claims examiner after judging whether the injury or illness is causally related to the claimant's work. But, since these 45-days or less cases do not involve payment of direct DOL compensation benefits, subsequent medical, drugs, and other bills are reviewed and paid by bill

payment clerks, not examiners. These payments are made without meaningful scrutiny by DOL officials.

We are told by DOL administrators on more than one occasion that bill payment clerks perform "accepted condition" checks, i.e., they ascertain whether medical treatment provided is consistent with the claimant's injury, before paying medical bills. We were told that bill payment clerks are closely supervised. Bill payment clerks, we were told, use medical dictionaries and pharmaceutical directories to relate the injury with the treatment or service rendered. Furthermore, we were told that the bill paying clerks work closely with the district medical directors in resolving complicated medical bills, including review of bills for reasonable costs.

Our interviews with bill payment clerks and our file reviews dispute what we were told. We personally witnessed payment of medical bills, irrespective of the amount billed, without any checks to relate the treatment with the claimant's accepted condition. No attempts were made, in the cases we have knowledge of, to verify whether treatment billed was actually rendered. And at no point in the bill payment process were questions asked about the need for a particular type of treatment, the cost of treatment, the length of treatment, repetitious fees, or "pattern" service dates. What we found instead was a provider, Dr. Josephs, who was paid and repaid for casting and recasting a claimant's wrist month after month, with no questions posed by DOL.

One of the cases in which Dr. Josephs was the treating physician finally captured the attention of a DOL claims examiner. The DOL district medical director was asked to comment on the type and length of medical treatment Hector Monthalvo allegedly received over 3 years for an inflamed elbow. Two years after the district medical director recommended that DOL arrange for Mr. Monthalvo to see a board certified orthopedic specialist, DOL claims officials finally decided to send Mr. Monthalvo to such a specialist for an impartial second opinion. Throughout this 2-year period, after concern had been raised by a claims examiner and district medical director, DOL continued to pay Dr. Josephs whatever he billed on behalf of Mr. Monthalvo's case.

Frequently we were informed by DOL administrators that the compensation laws are to be construed liberally in favor of the worker. We were also told that it would be a "conflict of interest" for claims examiners to investigate providers' claims. However, the practical result of this philosophy is to place the entire system at the mercy of claimants and medical service providers.

Private insurers, on the other hand, shared with us their commitment to claims verification as a means of cost containment. They contend that a close examination of all claims, both as to causality and cost, is a major factor in assuring the integrity of the claims process. Furthermore, early personal contact with claimants is also a factor in promoting timely rehabilitation.

While the compensation program managed by DOL makes the government one of the largest underwriters of disability insurance, fiscal management and disbursement of benefits under the program is often entrusted to low-paid clerks, without supervision or adequate instruction. Bill paying clerks and claims examiners rarely controvert medical treatment, according to our examination and the GAO. District medical directors can recommend that impartial medical expertise be sought on a case, but only when such cases are routed to the director's attention by the claims examiner or bill paying clerk. Medical bills seem to be automatically paid—at any rate—because there is no definition of what constitutes a reasonable medical charge, and there has been no attempt by DOL to create such a definition.

A 1975 DOL effectiveness study on the compensation program pointed out that "approximately one-third of current value of medical claims . . . may be unwarranted, as evidenced by the fact that nearly 10 percent of all medical payments are represented by total temporary disability cases with an excess over average payment of more than $4,000 each."

PSI staff found that medical cost containment efforts such as fee schedules and professional standards review boards are accepted medicare, medicaid and private insurer practices. Six years after the compensation program's effectiveness study, however, we found no evidence of attempts to implement medical cost containment. Indeed, we heard complaints from district offices that the newly created division of medical services and standards at national headquarters has been largely inactive in promulgating fee schedules and medical evidence guidelines. While we had been told that each of the 20 district offices has a medical

director in place, we learned that there is often minimal contact between the claims staff and these directors. At one office we were told of a recently hired, young physician whose addition to the claims staff was considered a coup. Later we discovered that this doctor worked 40 hours per week—primarily on weekends and evenings—effectively curtailing his interaction with the claims staff. Even when the medical director is available to the staff, work load rarely allows the director to spend any time providing cost containment guidance.

The DOL Inspector General's Office of Loss Analysis Prevention has recommended, in a February 1981 report of bill payment operations at District 25—Washington, D.C.—that schedules of customary provider fees be provided to the compensation offices. Officials of the Federal employees' compensation program commented on this report by noting that fee schedules would be identified and provided to each district office by May 1981. We talked with DOL about fee schedules in May and again in June of 1981. At first we were told that fee schedules and provider utilization profiles were impractical to develop and use, so therefore, fee schedules could not be developed. Later, it was explained to us that a fee schedule capability would be included in the automated data system due to be completed within the next several years.

It is worth noting here that this February 1981 internal audit of District 25 was precipitated by a loss event: One of the District's own employees misappropriated $50,000 of compensation funds by causing fraudulent medical provider bills to be paid. The scheme was never uncovered by DOL program administrators. We have been assured that this employee was fired—one day before she pleaded guilty to larceny charges.

We were consistently informed that DOL's current efforts to computerize the claims process would solve most problems with the system. Officials of the compensation program testified before the House Government Operations Committee in May 1981 that "the management information system is in effect in large measure and is providing timely, accurate production data . . ." Yet, the largest stumbling block in our investigation was the inadequacy of DOL's own computer system.

The management system designed to provide information on medical payments, we had been told, was fully operational at national and district offices. At the very beginning of our investigation, it seemed appropriate for us to request data on just how much money is paid out, by district office, to medical providers. We were assured that this information would be available for us overnight. Four weeks later we still did not have the requested statistics. When the information finally became available, we were advised that the delay was due to the fact that DOL had never devised a program to provide such information. A new program had to be created in order to respond to our request. Within 24 hours of receiving the statistics, we were told by DOL to discard the information as it had been found inaccurate. We were later sent another set of statistics.

We also assumed that an automatic fiscal management system could easily identify to whom medical payments are made. Such basic management information, however, cannot be retrieved from the DOL system. Even identifying medical providers does not produce results, since this entire system files payment history by the provider's Internal Revenue Service Employer Identification Number (EIN), not name. This identifier was arbitrarily chosen by DOL and has no relation to the claims made by the medical service provider.

Let us turn back to Dr. Josephs as an example. We had to request that the Postal Inspection Service locate his EIN. We gave DOL the EIN for Dr. Josephs; we in turn received a computer printout listing amounts paid under that EIN to Dr. Josephs, by claimants' names and case numbers. Twenty case files were identified for us, with the computer printout indicating that Dr. Josephs had been paid $22,000 for services rendered on these cases. Upon closer scrutiny we discovered from information kept with each file that DOL payments to Dr. Josephs added up to $50,000. The discrepancy can be explained, in part, by the fact that the automatic payment system stores information from late 1978 forward. More significant, however, was our discovery that medical providers often use more than one EIN, or that the EIN is manipulated or entered into the computer inaccurately. These identifying numbers are not cross-referenced or edited by the computer. Therefore, unless an investigator is aware of all EIN's utilized by the provider, it is impossible to identify how much money has been paid by DOL. We discovered five EIN's associated with Dr. Josephs, and along the way we also identified several more claimant cases in which he was the treating physician.

And as late as last week, we were informed of a sixth identifying number used by Dr. Josephs.

We went back to the data base several times to further check, each time in a different manner, the information stored. Conclusively, we can only state that each time we received another set of figures and that it was always at odds with previously retrieved information. From the 20 files we reviewed, we can piece together the fact that Dr. Josephs was paid $50,000 from late 1975 through 1980. There are other files, of course, which should be included in our review but the DOL has no way of positively identifying all of these files. And Dr. Josephs may be associated with EIN's other than those we know of at this time. Thus, $50,000 could represent the pinnacle of Dr. Josephs' Federal compensation practice—or it could just be the base upon which more money rests. Similarly, investigative work by the U.S. Attorney's office revealed six EIN's associated with Dr. Richard Kones' provider utilization report.

Another hurdle before us was that hard copy medical bills are not stored with claimant files. Hard copy medical bills were needed to ascertain exactly how much had been billed by a provider, the dates of treatment, and the precise services rendered at each visit. It became quite a cumbersome chore for the New York District Office to attempt to retrieve all of the hard copy medical bills for just three cases—those of Ms. Ryan and Messrs. Giannino and Monthalvo. To date, after 4 weeks of labor, the DOL is unable to completely reconstruct the files of these three claimants. Additionally, we are finding that hard copy bills, where available, do not correspond with the recapitulation summary in the claimant file, the DOL's computer bill payment history on the case, or the computer reports indexed by medical provider's EIN.

This seemingly elementary information becomes crucial when tracking the validity of treatments rendered and the flow of money from DOL to medical providers. Such evidence, as an internal management tool, is also needed to ascertain duplicate billings. In the Dr. Kones case, for example, we see indications that the physician received duplicate $5,000 checks for what appear to be same service dates and treatments. Yet without the hard copy medical bills to compare, we cannot make any such conclusions.

Similarly, from the material we gathered on Dr. Josephs earlier administrative hearing concerning his disqualification from New York medicaid practice, we found that one of Joseph's medicaid patients was a Federal employee. This claimant did indeed file a worker's compensation claim, and some of the treatment dates for which Dr. Josephs billed DOL match the dates for which Dr. Josephs billed New York for her medicaid treatments. We know that the question of duplicate payments occurred to medicaid investigators because DOL was asked, in 1977, to provide assistance and file information on this claimant. The medicaid investigative record indicates no response from DOL, and DOL's file do not contain any information about this correspondence.

Storing hard copy medical bills with claimant files, designing computer edit programs to cross-reference medical providers with EIN's used, and developing additional methods to accurately trace how much money is paid and to whom, will only begin to remedy the compensation program's weaknesses. More problematic is the fact that medical providers with past histories of fraud and abuse in the delivery of services to other governmental and private entities are not identified or excluded by DOL.

During the course of our investigative work we found a universe of previously identified medical providers who have been indicted or convicted of fraud and/or administratively excluded from Government or State medical benefit programs. We relied heavily upon the Postal Inspection Service as well as the nonprofit Insurance Crime Prevention Institute in Westport, Conn. to identify medical providers who had been indicted or convicted of fraud. Furthermore, State workers' compensation boards suspend or exclude medical practitioners from State compensation practice, as does the Health Care Financing Administration (HCFA) with respect to medicare and medicaid service providers. An integral part of HCFA's validation program is automatic suspension whenever a medical practitioner is convicted of a criminal offense related to involvement in the medicare or medicaid program. Since November 1977, 153 physicians and practitioners have been suspended while 56 others have been excluded from the HCFA program.

DOL contends that under its current practice it is powerless to act against these medical providers because the Secretary of Labor has regulated that the possession of a professional license is the only prerequisite needed to submit medical claims. Due to the prevailing attitude among professional licensing

boards that fraud and abusive practices do not equal medical malpractice, it is not unusual to find many convicted felons who retain their professional licenses. Referring back to each of the three medical providers we have discussed today, we find that each one is eligible to continue practicing Federal worker's compensation cases:

DOL does not protect itself against providers such as Dr. Thomas Dent, who are convicted of workers compensation fraud. Dr. Dent received a suspended sentence, paid a $9,000 fine, and must perform 250 hours of community service as a result of his May 1981 fraud conviction. To date, however, his medical license has not been revoked.

DOL does not protect itself against providers who have been convicted of other kinds of medically related claims fraud. Dr. Richard A. Kones, twice convicted of medical service fraud, currently under indictment in New York for $2 million of Federal workers' compensation and other insurance fraud, is eligible to continue practicing before DOL. If a debarment or administrative exclusion action had been taken based on his two prior convictions, DOL would not have become victim to Dr. Kones's lates alleged fraud scheme. And, if convicted of the pending charges against him, Dr. Kones will still be eligible to treat, bill and receive payment for Federal workers' compensation cases—unless his license is revoked by the State of New York, which did not occur after his first conviction.

DOL does not protect itself against providers such as Dr. Thomas Dent tively disqualified from the provision of certain kinds of medical services. Dr. Josephs' prior administrative exclusion from State medicaid practice did not preclude his involvement in Federal workers' compensation cases. Similarly, we have learned from the New York State Workers' Compensation Board that a July 28 hearing will be held to pass upon a recommendation that Josephs authority to practice State workers' compensation be revoked. New York State estimates that Dr. Josephs received more than $60,000 in State compensation claims in 1980 alone. Yet an administrative exclusion from the New York program will again not bar Dr. Josephs from practicing Federal workers' cases.

And we know for a fact that Dr. Josephs billed DOL throughout the period of his indictment and sentencing until the last 4 days before his incarceration, yet DOL claims it is powerless to deny this physician the authority to participate in its program.

A sensible solution to these situations is an exclusion or debarment provision which could be administered against medical providers indicted or convicted of false claims fraud as well as those who have been otherwise prohibited from delivering medical services in Federal, State or local government programs.

The concept that a professional license does not insure honesty is hardly a novel one. But, by failing to grasp this concept, and by failing to guard against systematic weaknesses which encourage program misuse, DOL exposes itself to waste, fraud, and abuse.

III. Prepared Statement of Morton E. Henig, Senior Associate Director, Human Resources Division, General Accounting Office

Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss a number of GAO reports issued in the last few years on the Department of Labor's Federal Employees' Compensation Program, as well as our recent followup work requested by this subcommittee. Since June 1978, we have issued 6 reports to the Congress on the program with 13 recommendations to Labor for improvements in administration, 5 recommendations to the Congress for legislative action, and 1 recommendation to the Office of Management and Budget which could enable Labor to delegate certain program responsibilities to the employing agencies. We plan to issue a report on the timeliness of claims processing within the next few weeks.

The major problems disclosed by our reviews were:

Personnel and administrative inadequacies in the program had contributed to untimely, inaccurate, poorly documented, and inconsistent claims determinations.

The 1974 amendments to the Federal Employees' Compensation Act (FECA) which provide for continuation-of-pay (COP) without a waiting period after an injury, resulted in a dramatic increase in the number of minor and frivolous claims that diverted Labor's efforts from more serious claims.

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Federal agencies' participation in the data gathering, COP, monitoring, rehabilitation, and appeals process has been limited or neglected; although the agencies must bear the costs of the FECA program.

The act creates incentives for workers to claim and in some cases retire on compensation because of its benefit structure which, in some instances, provides benefits higher than pre-injury take-home pay.

Labor's decisions over the years have provided an expansive interpretation of what constitutes a compensable injury under the program, and coupled with broad definitions, inadequate guidelines on the work relatedness of diseases, and uncertainty about the causes of many diseases, have resulted in expanded program coverage.

The administration's proposed legislation, "Federal Employees' Reemployment and Compensation Amendments of 1981," included in H.R. 3982, the Omnibus Reconciliation Act, 1981, addresses the waiting period, COP, reconsideration of decisions, and the reduction of the benefit levels. While we can not evaluate the effectiveness of these specific items until they have been operational for a reasonable period of time, we believe they address some of the deficiencies in the design of the program.

The main purpose of our followup work was to ascertain Labor's actions with respect to our prior recommendations. Our work was performed between April and July 1981 at the Labor headquarters and the district office in Washington, D.C., and was coordinated with our review of timeliness of claims processing recently performed at the district offices in Jacksonville, Fla., Cleveland, Ohio, and Denver, Colo. Due to time contraints, we did not review a sample of recently settled disability claims to ascertain whether recent Labor actions have resulted in improved claims adjudication. Further, because the subcommittee staff was reviewing individual medical bill payments we did not include this area in our work.

FECA PROGRAM LACKED ADEQUATE PEOPLE, POLICIES, AND PROCEDURES FOR PROPER ADMINISTRATION

In our past reports, we said that: 1) Program staffing had not kept pace with the increased FECA workload, (2) claims examiners were not adequately trained, (3) benefits were awarded without adequate evidence, (4) policies were such that disapproved benefit claims were more stringently reviewed than approved cases, (5) the management information system did not give management necessary information on timeliness of claims processing, and (6) Labor's guidelines lacked minimal factual and medical standards for award determinations. GAO made a number of recommendations to Labor regarding the administration of the FECA program. We identified the need for: Additional claims processing personnel, improve training of claims examiners, supervisory review and certification of claims dispositions, the institution of a management information system, and issuance of guidelines with at least minimal factual and medical standards for deciding whether an injury is compensable under the act. Labor has initiated actions in each of these areas, but more can be done.

OVERWORKED AND INADEQUATELY TRAINED PERSONNEL ADMINISTERED THE PROGRAM

In our 1978 report,[1] on improvements still needed in the administration of FECA, we recommended that Labor consider additional staffing requirements. In August 1978, Labor evaluated its long range staffing needs and concluded that additional staff were needed. To control the critical workload problem, the number of employees to administer the program was increased from 753 in 1977 to 980 in March 1981. The number of full-time FECA claims examiners was increased from 319 to 367.

Labor has also initiated training programs for the claims examiners. Newly hired examiners attend a basic course which includes topics such as:

FECA background,
Basic requirements for claims adjudication,
Policies on controversion of continuation of pay,
Procedures for accepting and denying cases, and
Medical terminology.

[1] Report to the Congress, "Improvements Still Needed In Administering The Department Of Labor's Compensation Benefits For Injured Federal Employees" (HRD–78–119).

The course allows claims examiners to follow both a simple traumatic and nontraumatic injury case through all phases of the process. Upon completion of the course they should be capable of developing relatively uncomplicated cases with minimal supervision. Only 14 of the 367 claims examiners had not attended this course as of May 1981.

After about 1 year of on-the-job experience, the examiners attend another formalized, advanced course which helps the claims examiner understand complex medical reports and handle more difficult cases such as occupational diseases. Third party claims, handling death cases, recurrences, continuation of pay, and pay rate computations are other topics covered in this course. Of the 367 full-time claims examiners, 55 have not attended the advanced course.

Labor officials indicated that formal and intensive training has resulted in significant improvements in the processing time for traumatic injury cases and the quality of case dispositions. While the processing time may be improving, Labor is still not meeting its prescribed standards, as will be discussed later in this testimony.

Although claims examiners are now receiving training in nontraumatic—occupational disease—case adjudication, Labor has not yet established adequate guidelines for such cases. The FECA procedure manual currently directs claims examiners to obtain more detailed case history information for nontraumatic claims than for traumatic cases, but offers little assistance in actual case adjudication. Labor is currently updating and expanding the medical portion of the manual, but still lacks adequate interim guidelines on occupational diseases.

FECA PROGRAM: LACKED MANAGEMENT CONTROLS

To improve both the timeliness and the quality of claims adjudication, in our 1978 report we recommended that Labor:

Place as much emphasis on decisions to approve or continue compensation as it does on decisions to reject, terminate, or reduce compensation, and

Install a management information system that will give managers at all levels the information they need to insure that activities are being conduced in accordance with the act and established criteria.

According to Labor, the work of the claims examiner is now subjected to several reviews. First, all claims—approved as well as disapproved—are supposed to be reviewed by a second party at least at the supervisory level. Specifically:

All unadjudicated claims are subjected to mandatory supervisory review at 30 day intervals for evaluation of the quality and evidence requirements.

Approved claims require supervisory certification on all compensation payment authorizations, death benefit cases, and scheduled awards.

Long-term disability cases are reviewed by district offices. Labor estimated the savings from these reviews to be about $17 million in fiscal year 1980.

Second the regional and national offices conduct accountability reviews of approved cases to identify processing deficiencies and the need for closer supervisory review or additional training. The national office accountability reviews have found significant improvement in case disposition.

In our 1978 report we also noted Labor's inability to track and manage cases, and recommended the institution of a management information system which would do so. Labor has since developed two types of automated systems to assist in program administration. The management information system generates reports for management. The operational reporting system directly supports the claims examiners and line supervisors. Labor has testified that the operational reporting system is reducing claims processing time and that with planned expansion to include an automated compensation payment system, claims processing should be expedited. Because the system is not fully operational, we did not evaluate its effectiveness.

Although Labor has improved its timeliness for claims processing, it is not yet meeting its prescribed standards. For traumatic cases, Labor's standard states that 85 percent of the cases should be processed within 38 days of receipt. Only 4 of Labor's 15 district offices, however, were able to meet this standard. For nontraumatic cases, only one district was able to meet or exceed the standard which requires a determination on 85 percent of the cases within 5 months. Labor stated that on a national basis, however, 78 percent of the traumatic cases and 40 percent of the nontraumatic causes were processed within the prescribed timeframe.

We conclude that while Labor has not completed action on past recommendations, plans have been initiated to alleviate administrative and personnel inadequacies in the present program. Due to time constraints, we did not review a sample of recent cases to determine the effectiveness of these initiatives. However, we identified staffing improvements, systems, procedures, and controls which Labor officials believe will improve case management and processing when fully implemented.

THE 1974 AMENDMENTS: AN AID TO INJURED EMPLOYEES; A STAGGERING BURDEN TO THE GOVERNMENT

Since the early part of the 20th century, injured Federal employees have been permitted to claim workers' compensation; however, prior to the 1974 amendments to the act, employees were often left without income awaiting government approval of their claims. No compensation was provided for the first 3 days—the waiting period—unless the disability lasted more than 21 days. Many injured employees opted to use personal leave instead of compensation for short duration injuries because of this waiting period. Those with injuries of longer duration, however, sometimes suffered financial hardship caused by delays in processing claims and preparing compensation checks.

The FECA amendments of 1974 provided for the continuation of an employee's pay (COP) after a job-related traumatic injury for 45 days prior to the 3-day waiting period and subsequent compensation. The COP provision was meant to eliminate the gap in an employee's cash flow resulting from Labor's claims processing delays, reduce the backlog of claims, and thereby reduce Labor's processing time.

We reported in 1978 that the number of lost-time injury claims filed by Federal workers escalated sharply after the amendments. In fiscal year 1974, about 12,000 claims for job related lost-time injuries were filed. By fiscal year 1976, the first full year the amendments were in effect, the number of such claims had risen to about 80,000 and we estimated that the COP provision was costing the Government about $45 million in that year alone. Furthermore, we believe that as many as 46 percent of all claims might have been eliminated by instituting a 3-day waiting period before receiving COP. During the first half of fiscal year 1981, over 80,000 injuries were reported. In the absence of legislative amendments to institute a waiting period before COP as recommended in our past report, we believe Labor will be facing an increasing number of reported injuries and costs.

Labor's proposed legislation would both eliminate continuation of pay and institute a waiting period before starting compensation. In place of COP, this proposal would authorize the agencies, at their discretion, to advance compensation to disabled employees if there is sufficient evidence that a serious work-related disability was involved. A 7-work day waiting period would be provided with 5-days being compensable after 14 calendar days of disability.

AGENCY PARTICIPATION: MORE NEEDS TO BE DONE

Employing agencies' participation in the Federal Employees' Compensation Program has been neglected. Although the agencies must bear the burden of employee absence and the associated continuation of pay and compensation costs, they have limited ability to controvert COP and no right to appeal compensation decisions. Furthermore, agencies have not been assigned specific responsibilities for onsite evidence gathering when warranted, or monitoring their workers' recovery and rehabilitation. Labor's current rehabilitation and monitoring programs—which consists of about one person-year per region for investigations—are not adequate to encourage recovered workers' speedy return to gainful employment.

AGENCIES AUTHORITY TO CURB EMPLOYEE CONTINUATION OF PAY ABUSES LIMITED

Since the passage of the 1974 amendments, Federal agencies have been responsible for making COP payments to injured employees, placing the agencies in a more prominent role in developing traumatic injury cases. However, we believe Labor has not provided the Federal agencies with sufficient authority to go along with their responsibilities. Agencies can not withhold COP without Labor's approval except in certain limited circumstances. In a June 1979 report,[2]

[2] Report to the Congress, "Multiple Problems With The 1974 Amndments To The Federal Employees' Compensation Act," (HRD–79–80).

we recommended that the agencies be given the authority to withhold COP in controversial cases, for claims that lack adequate medical evidence, and when medical evidence indicates that the employee is able to return to light duty but refuses to do so.

While recognizing the need to address claimant abuse, Labor in its response to our 1979 report did not agree that the agencies should be permitted to withhold COP in the absence of adequate medical evidence. Labor's current legislative proposal appears to address the program abuse by claimants through eliminating continuation of pay and instituting a 7-day waiting period before the start of compensation.

AGENCIES LACK REPRESENTATION AND APPEAL RIGHTS IN LABOR'S ADJUDICATION PROCESS

To avoid an adversary system, Labor excluded Federal agencies from directly participating in the adjudication process. Agencies are permitted to submit affidavits and other relevant probative statements regarding claims. However, the agencies are excluded from the proceeding; they often are not informed of the rationale for Labor's decisions; and in some cases they have unresolved questions of fact regarding the case. Labor's proposed legislation does not give Federal agencies appeal rights, but it does address this situation to a limited extent. If the claim was submitted by the agency in a timely manner, Labor would be required to respond to the agency's request for reconsideration of the initial compensation decision. However, we do not believe that this proposed action is adequate to insure the quality of compensation decisions and provided definite resolution for additional questions of fact. Accordingly, we continue to believe that, when an agency feels it has adequate evidence to question Labor's decision, the agency should be able to appeal the case to the Employees' Compensation Appeals Board.

INCREASED PERSONAL CONTACT: POTENTIAL FOR BETTER PROGRAM ADMINISTRATION

Our current work on delays in paying compensation benefits and a prior report noted that Labor uses a through-the-mail operation for claims processing rather than one of onsite investigations and personal contact. We found that when the claims examiner is faced with suspect, conflicting, or inadequate evidence, effective claims adjudication is difficult at best. Present reliance on through-the-mail operations is time consuming and often will not generate the necessary information. Officials from Labor and other Federal agencies have said, and we concur, that increased responsibilities should be placed in the agencies for gathering injury data and medical evidence, as well as assisting injured employees in establishing claims.

In our 1978 report to the Congress, we noted the workers' compensation insurance industry emphasizes immediate, close, continued personal contact with injured employees. We found that Labor lacked the resources to adequately monitor disabled employees' recoveries and provide for vocational rehabilitation and reemployment of recovered workers. Although Labor has tried to alleviate these conditions by hiring and training claims examiners, training employing agencies' claims specialists and entering cooperative agreements with two major employing agencies, the program continues to lack vital personal contact. Labor continues to allow months to elapse after injuries before considering employees for rehabilitation. As a result, agencies are left compensating many substantially recovered, but unmotivated claimants.

Federal agencies with offices geographically dispersed throughout the country have better access to their injured employees, and they can perform evidence gathering, monitoring and rehabilitation activities more effectively than Labor. By providing Federal agencies with this authority, we believe an increased number of injured employees could be returned to gainful employment.

LABOR PROJECT IDENTIFIED CLAIMANT ABUSE

In July 1980, to ferret out abuse, Labor initiated a pilot project with investigatory personnel from the Employment Standards Administration's Wage and Hour Division. Thirty-eight cases on the long-term disability rolls in the Boston area were selected. By studying these 38 files, interviewing the claimants, and gathering information about the current extent of the claimant's disability, Labor was able to reduce the amount of annual compensation paid to 19 claim-

ants by about $243,000. This pilot project demonstrates the need for an onsite investigation to insure that existing and future claims for compensation are valid and that potential misuses are curtailed.

INSPECTOR GENERAL FECA EFFORTS HAVE BEEN LIMITED

During this fiscal year, 193 cases of suspected FECA abuse were referred to the Office of Inspector General for investigation. Results of FECA investigations by the Office of Inspector General over the last 2½ years include:

Seventy-five cases referred to the U.S. Attorney for prosecution,

Thirty-four cases returned pending further action—or administrative action, and

Nineteen indictments which resulted in eleven convictions.

Additionally the Office of Inspector General, in cooperation with seven Federal agencies, recently instituted a demonstration project in the Atlanta region to review the files of selected long-term disability cases. This effort identified 20 cases in which Labor was able to reduce, terminate, or suspend benefits. The agencies also initiated criminal investigations of 130 claimants.

We referred an additional 36 FECA fraud and abuse allegations reported over the GAO "Hotline" to the Labor Office of the Inspector General for investigation. For 16 of the cases, the Office of Inspector General made investigations. Three of the cases were later referred to the U.S. Attorney for prosecution.

While Labor's proposed legislation would eliminate the need to controvert COP and give Federal agencies the ability to seek reconsideration of Labor's decisions, potential exists for more agency involvement in onsite evidence gathering investigations, monitoring and rehabilitation. We believe that post adjudication investigations are effective in identifying claims which lack current justification. We believe cooperative investigative efforts by Labor with other Federal agencies should be continued and expanded throughout other districts.

COMPENSATION BENEFIT LEVELS ARE TOO HIGH

In March of this year we reported to the Congress[3] that wage-loss compensation levels need to be decreased to encourage injured employees to return to work or seek reemployment. Injured employees do not have the incentive to quickly return to work because continuation of pay provides them take-home pay without interruption, and workers' compensation benefits remain at a level where the difference between wage-loss compensation and normal take-home pay is negligible. In fact, above the GS–12 level, wage-loss compensation exceeds normal take-home pay.

In 1916 when FECA was enacted, the personal Federal income tax rate was about 2 percent of net income, and few workers had incomes large enough to be subject to the tax. Thus, a benefit payment of 66⅔ percent of gross salary represented a significant decrease in net pay to the Federal employee. The individual lost almost ⅓ of the spendable income and was, in essence, sharing the burden of risk. Therefore, the worker had a financial incentive to return to work as soon as possible.

The effects of today's Federal and State income tax structures in conjunction with the present level of FECA benefits have negated the concept of sharing the burden of wage loss in work-related injury cases. Since individual income taxes have become so significant and FECA benefits are not taxed, ⅔ to ¾—when dependents are involved—of one's gross pay in the form of wage-loss compensation provides employees nearly as much, and often higher take-home pay than received when they were working. For example, the biweekly net pay of a GS–7 employee claiming four exemptions is $388. The amount of compensation benefits received biweekly by the same GS–7 is $352; or 91 percent of normal take-home pay. A GS–13 employee, claiming four exemptions has a biweekly take-home pay of $738, but under tax-free compensation benefits, the individual is entitled to $768 biweekly or 104 percent replacement of net pay. A system which results in a pay loss for the lower grades and pay gains for senior employees is not only inequitable but also fails to implement the concept of sharing the burden of loss between the employer and employee thus providing the economic incentive for the employee to be rehabilitated and return to work.

[3] Report to the Congress, "Federal Employees' Compensation Act: Benefit Adjustments Needed To Encourage Reemployment And Reduce Costs" (HRD–81–19).

Labor's proposed legislation will address benefit levels. One of the recommendations is to adjust the compensation rate to replace 80 percent of an employee's spendable income—defined as gross pay less standard deductions—and eliminate increased benefits for dependents. The intent of this legislative proposal is consistent with our belief that benefit levels must be reduced to encourage reemployment of injured workers.

EXPANSIVE INTERPRETATIONS INCREASE PROGRAM COVERAGE

While legislative changes to the FECA and an increasing awareness of health hazards in the workplace have contributed to broadening the range of compensable injuries, Labor's liberal interpretation of the act's provisions has figured significantly in extending the act's coverage over the years. For example, Congress in the 1924 amendments to the act provided that the definition of compensable injury include, in addition to injury by accident, a disease proximately caused by the employment. Thus, occupational diseases became compensable under the and, and its determination was left solely to the judgment of the act's administrators.

In deciding whether to amend the act, the House Committee on the Judiciary (67th Cong. Feb. 7, 1923) debated the meaning of "proximate cause." A member of the U.S. Employees' Compensation Commission—then responsible for administration of the act—defined it as "* * * the last cause without which the disability would not have resulted" and said that the test of work relatedness was whether the disease resulted beyond a reasonable doubt from employment conditions.

Committee members, however, were concerned about the vagueness of the term. Loosely construed, it could result in almost any disease—the common cold, for example—being considered work related. In defining "proximate cause" Labor generally follows the decisions of the Employees' Compensation Appeals Board which has ruled that: "Proximate cause is used in its normal legal sense, that which, in a natural and unbroken sequence produces the injury, and without which the injury would not have occurred." (4 Empl. Comp. App. Bd. 311 (1951).)."

The FECA procedure manual expands the definition of "proximately caused" to include: "Due to, precipitated, accelerated, or aggravated by conditions of Federal employment."

The concept of aggravation, instead of clarifying "proximately caused," tends to raise additional questions. While in some cases it is clearly applicable—for example, when a job-related accidental injury renders an already impaired limb useless, other cases are not so simple and are much more subjective, especially those involving pre-existing diseases such as arthritis, heart conditions, and mental problems. Such diseases are often aggravated by both job-related and non job-related factors. If the disease is chronic and degenerative and disabiilty or death is inevitable, how can it be determined that aggravation hastened a disability or shortened a life? Even more difficult is trying to distinguish aggravation due to (1) conditions at work, (2) conditions of the off-duty environment, and (3) personal habits both at work and off duty. Apportionment between employment and nonemployment factors is possible, but could result in the same unsystematic and necessarily arbitrary guesswork already involved in claims based on aggravation.

The act's provision that diseases are compensable if "proximately caused" by employment does not provide adequate guidance, especially for diseases that present difficult etiological problems. Although Labor is presently updating and expanding its guidelines for adjudicating occupational disease cases, these same guidelines recognize that "the medical profession has thus far been unable to completely develop the etiology of these diseases" and therefore "medical opinions which are equivocal or in conflict concerning the question of causal relationship are to be expected". The procedural manual currently directs the claims examiner to obtain opinions from physicians who have specialized or advanced training in the specific field of medicine which is involved in each case. Even in those cases where guidance is available to the claims examiner, however, the existence of causal relationship may still remain ambiguous. If, given medical uncertainty over the cause of many diseases, meaningful guidelines are not possible, the basic question of whether a particular disease should be covered by the act may require a policy decision by the Congress. When the etiology is uncertain, we believe that the Congress should decide whether, and under what conditions, a particular disease will be covered by the act.

Labor has initiated administrative actions on a number of past GAO recommendations. For example, Labor made a review of the long-term disability rolls with an estimated savings of $17 million in fiscal year 1980, initiated a training program for Federal agencies' claims specialists, alloted additional positions for claims examiners, initiated a formal training program attended by over 85 percent of the claims examiners, and entered into interagency agreements with the Tennessee Valley Authority and Postal Service regarding areas of mutual concern.

Additionally, Labor has proposed legislation included in H.R. 3982, the Omnibus Reconciliation Act, 1981, which would give agencies increased responsibilities and would permit increased involvement in claims determinations. The agencies would be obligated to promptly submit relevant evidence in FECA cases, and with this would go the obligation of Labor to consider the evidence and inform agencies of their disposition. Further, the proposed legislation would authorize the reconsideration by Labor of an initial decision upon the timely request of an agency.

However, while Labor has taken or planned actions to improve the administration of the Federal Employees' Compensation Program, there are inherent problems with the original program legislation over which Labor has no control. We believe Congress should take the following actions to improve the administration of the program:

Enact Labor's proposal to eliminate continuation of pay and institute a waiting period prior to compensation; or if, however, the Congress chooses not to adopt Labor's proposal, a waiting period prior to the start of COP should be enacted.

Direct OMB to consider placing in the employing agencies specific onsite evidence-gathering, monitoring and rehabilitation responsibilities. If the Director, OMB, determines that such delegation is feasible, he should submit legislation to the Congress to so amend the act.

Reduce compensation benefit levels to reestablish an incentive for injured employees to return to work.

Determine whether actual administrative practices—such as Labor's expansive interpretation of "proximate cause" to include aggravation—conform to congressional intent, and in those cases where the etiology of an illness is uncertain, whether, and under what circumstances, those particular diseases will be covered by the act.

Mr. Chairman, this concludes my prepared statement.

IV. Prepared Statement of Mr. Thomas F. McBride, Inspector General, U.S. Department of Labor

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to appear before you today to discuss OIG efforts related to the existence of fraud and abuse in the Federal Employees' Compensation Act (FECA) program, which is one of the programs administered by the Office of Workers' Compensation Programs (OWCP) in the Department of Labor. I have discussed the problems of fraud, waste, and abuse in the OWCP programs with Secretary Donovan. I have also had an in-depth and productive conversation with Deputy Under Secretary Collyer. At that meeting, we specifically addressed our mutual concern with the FECA program and he has already taken initiatives. Both Secretary Donovan and Deputy Under Secretary Collyer share our concerns about the FECA and strongly support the efforts to reduce fraud and waste and to improve management in the FECA program. They expressed their concern about the problems and support my efforts.

Six major initiatives have been completed or are underway. I shall briefly summarize them. In December, 1980, we completed an audit "Review of FECA Periodic Roll Case Management." The FECA periodic roll is comprised of long-term disability beneficiaries. Our review was to determine if these cases were properly managed.

Compensation paid by the district offices that were reviewed represented more than 20 percent of the approximately $778 million in FECA compensation paid during fiscal year 1980.

We also issued a report "Loss Vulnerability Assessment of FECA Bill Payment Operations and Procedures at the Division of Federal Employees' Compensation District Office 25," which is the Washington, D.C. office. This report covered

various aspects of bill payment including bill processing, bill examination and data entry preparation and transmission.

The problems in the District 25 bill payment system that were uncovered led to the study, "Loss Vulnerability Assessment of FECA Benefits Payment Program Operations in Six District Offices." The six district offices that were reviewed were: District Office 25 and District Office 50 in Washington, D.C.; District Office 7 in New Orleans; District Office 3 in Philadelphia; District Office 10 in Chicago; and District Office 13 in San Francisco. This study reviewed the recommendations in the previous District 25 study and expanded on the scope of that study to include other areas of potential vulnerability to loss from fraud and abuse. The following functions were reviewed: Mail and file, claims processing, bill payments, compensation payment and computer security.

In mid-1980, we undertook a project in the Atlanta region to determine to what extent there were incidents of unreported income or employment by FECA beneficiaries. The OIG determined that a large-scale review was necessary to achieve a deterrent effect; this effort was known as the Atlanta FECA project. A task force was established comprised of law enforcement agents from organization such as FHS, DOT, Air Force, Navy, V.A., Postal Inspection Service and Agriculture. A profile of potential abusers was developed and the task force identified claimants who met the criteria on the profile. These claimants were matched against State unemployment insurance records and credit bureaus to determine if they earned any other income.

One major outgrowth of the Atlanta FECA project is the FECA matching project. The purpose of the FECA matching project is to determine the amount of improper FECA benefits. This is done by matching FECA beneficiary recipient data with beneficiary recipient data from such sources as unemployment insurance, social security disability, as well as numerous other programs. All three DOL worker compensation programs, FECA, Black Lung and Longshore, will be matched against one another and against as many as 18 other benefit programs, contained within three other Federal agencies. Additionally, we are considering matching with the DOL programs six Federal retirement programs and a number of private insurance carriers. This project is in the initial stages.

It has been our experience that some recent fraud cases have been lost in the courts or have been declined by the U.S. Attorneys because of poorly constructed OWCP reporting forms that have not clearly framed requests for information or data. These forms have permitted ambiguous answers by the claimant. Therefore, we initiated a project to review and recommend revision of selected FECA forms.

As well as our major initiatives, the OIG has conducted investigations of the FECA program. Since March, 1979, the OIG has initiated 279 criminal investigations within the FECA program. Of these investigations, 61 were referred to U.S. attorneys for prosecutive action. To date, there have been 40 indictments and 23 convictions in this area. We currently have 158 cases pending. Allegations regarding FECA violations come from many sources. Of the 279 criminal investigations mentioned previously, the OWCP has referred 150 incident reports that allege fraud. Of these allegations, 10 relate to medical provider fraud and 4 relate to legal provider fraud.

I shall briefly now discuss the findings and the recommendations that have resulted from our recent work.

The audit of the periodic roll case management that was issued last December resulted in 36 recommendations, including: The development of a checklist that would match the five statutory requirements of eligibility to information on the claimant's application, with particular emphasis to the casual relationship of employment to the claimant's medical condition; the requirement of having the employing agencies investigate every work-related injury and submit a copy of the report of the investigation to OWCP; and the development of a periodic medical form which emphasizes the determination of the claimants' current disability status and the necessary future actions for the further development of the claimant's medical condition. In terms of implementation of these recommendations, OWCP has issued a directive to the field that restated the necessity of a checklist, but has not developed the checklist yet since ADP system, planned for 1984 implementation, will perform this function. Next, OWCP has also issued a manual that has a section, emphasizing the necessity of obtaining satisfactory evidence of the injury from the employing agency. OWCP is in the process of issuing a memorandum to the employing agencies outlining their responsibilities. Finally, OWCP has not issued a periodic medical form since it was not possible to devise a single form for all conditions. Instead, they have

issued various forms for certain conditions, such as a lower back condition, and have issued numerous directives for obtaining and evaluating medical evidence.

The study, "The Loss Vulnerability Assessment of FECA Bill Payment Operations and Procedures at the Division of Federal Employees' Compensation District Office 25" contained many findings. The overall finding is that there were significant weaknesses because of the lack of well-designed internal controls. These weaknesses included the lack of basic controls such as: Computer and terminal security, logging procedures, separation of duties, document control and integrity, adequate monitoring of conformance with requirements, provider/claimant profiles and inadequate password security. Recommendations to correct these weaknesses included: Conducting periodically a computer and data security risk analysis, assigning a security officer to insure compliance with security standards, maintaining data entry terminals and bill payment terminals in secure areas, rotating terminal operation duties after a reasonable period of time, controlling single person access to all parts of the system and restricting access to the ADP room.

The followup report "Loss Vulnerability Assessment of FECA Benefits Payment Program Operations in Six District Offices" also corroborated that weaknesses identified in district office 25 were present in the six district offices reviewed. This report suggested that weaknesses are likely to exist throughout the majority of the district offices. Findings included: Inadequate control in the mail and file area over access to case files; inadequate control over returned checks; need to separate bill review, batching and data entry activities; inadequate verification procedures for reimbursement of medical payments to claimants; need to initiate verification procedures for medical services provided; lack of consistent procedures for certification of payment authorizations; allowing claimants to transmit medical records from physicians to Division of Federal Employees Compensation district offices, inadequate review of manual payments; and the lack of guidelines for determining "usual and customary fees" for specific medical treatments. We made a number of recommendations to correct these problems. OWCP is currently reviewing our recommendations and is preparing a response.

The Atlanta FECA project has disclosed a large percentage of administrative discrepancies in claimants files. A total of 827 cases out of 1,810 case files reviewed were referred to OWCP for consideration of follow-up action. To date, OWCP has returned 682 review forms to the OIG national office. In over 20 instances, OWCP was able to take immediate action in either terminating, suspending or reducing benefits paid, which resulted in an immediate savings of $16,000 per month. OWCP personnel are continuing to followup on the administrative actions found and are providing our office with their findings and actions taken. Further reductions in benefits paid are anticipated as the administrative files are corrected. Task force members have initiated criminal investigations on over 130 claimants as a result of the income/employment check and file review. These investigations are currently in progress. The OIG will expand the Atlanta FECA project to include the nine other DOL regions.

The project concerned with revising selected FECA forms has resulted in the OIG recommending that five forms be revised. For example, we recommended that the form CA–1032 be revised. This form is issued annually to beneficiaries on the automatic payment rolls and requests beneficiaries to notify OWCP of any change in status that could affect the amount of benefits received. The revised form includes a clarification of self-employment, a correction to the penalty notice, and expansion of the certification statement. Thus far, OWCP has implemented three of the five recommendations and is still considering the two other recommendations.

As the testimony has previously suggested, there are many weaknesses within the FECA program which allows the system to be abused.

For example, a FECA bill payment clerk pleaded guilty to a scheme in which bogus bills for health care services were submitted. The clerk placed legitimate case numbers on bogus bills and used inactive cases to avoid detection. When necessary, the clerk also falsified authorizing initials to circumvent computer edits on maximum payment levels that are permitted without certification. A total of 65 checks worth $52,005 were issued as a result of this scheme. A total of $22,300 was recovered and the clerk was terminated from the job at OWCP. It should be noted that the scheme was uncovered by nondepartmental sources and that the scheme had not been detected by routine OWCP auditing applications.

We are also currently investigating a former Federal employee, who was placed on disability retirement and subsequently, had a FECA claim approved for aggravated osteoarthritis of the spine. The employee's physician certified that the claimant's condition was deteriorating and that the claimant was supposed to limit his activities. On three occasions, this employee was observed playing tennis, including one time with physician who certified his condition.

In addtion to these numerous individual examples, there are a number of systemic weaknesses. For example, in District 25, photocopied bills were accepted for processing. This made dual payments possible because alterations to the original copy as well as to photocopies would be difficult to detect. Also, there were instances in District 25 when the file information did not match the computerized employee identification number provider file—which contains the employee identification number and social security number—for a substantial number of direct payments. We observed an instance when the key punch operator routinely typed in the name and address on the photocopied bill. As one can see, this practice serves to facilitate fraudulent payments.

OIG staff has brought to my attention some of their concerns regarding their work in FECA. Foremost, among these concerns is that OWCP in the past has not been as responsive as they might have been in implementing recommendations made by the OIG. For example, the OIG recommended that OWCP develop a fee schedule of providers to assist the bill payers to determine the reasonableness if fees. OWCP has stated that they are aware of the limited effectiveness of their current guidelines. However, OWCP also stated that the fee schedule should be based upon usual and customary charges developed from their actual expenses with billing data. OWCP expects that the free schedule will be an integral part of their planned FECA ADP system, "Level II," however, this system is not expected to be operational until October 1984. OWCP has stated that there would be problems in implementing the fee schedule before the "Level II" system is operational. In light of the necessity for a fee schedule, and other needed improvements in FECA case management, the OIG, will recommend that OWCP accelerate the development of the planned ADP system.

In other instances, where OWCP readily concurs with OIG recommendations, the implementation of the recommendations seems, in our opinion, to take much too long. For example, the audit report, which was issued last December, recommended that OWCP require the employing agencies to investigate every work-related injury and submit a copy of the report of the investigations to OWCP. Although new guidelines in the manual specifically emphasized this policy, a memorandum to the employing agency that outlines the evidence needed and emphasizes the necessity of obtaining satisfactory evidence of the injury has still not been released and is not expected to be released for another 4 to 6 weeks.

I would like to commend OWCP for accepting and implementing many of our recommendations. I also recognize that OWCP has made significant improvement to their system over the past several years. At the end of fiscal year 1977, the FECA program was paying medical service bills on the average of 71 days, whereas FECA now routinely pays 80 percent of payable bills within 28 days of receipt. Previously, the FECA district offices would receive two or more submissions of the same bill, since FECA was unable to process payments before more than two billing cycles passed. The operational impact of such a hugh work load on a manual system cannot be underestimated. While the operational impacts of this workload were severe, so were the potential for fraud and abuse. Also, it appears that as the result of the OIG studies OWCP has begun to initiate actions which may lead to the resolution of many payment, and financial control deficiencies. Most significantly, OWCP's fiscal year 1983 budget submission reflects a total reversal in program orientation and proposes the agency's first serious commitment to the accomplishment of loss prevention and financial control objectives since the passage of the 1974 amendments. We are gratified that the OIG studies appear to have already had a substantial impact upon the agency's interpretation of is mission. However, the historical priority assigned by OWCP to processing and paying claims to the exclusion of adequate control over resources, raises questions as to whether the current initiatives will be brought to fruition.

Another concern of mine is the lack of effort on the part of the employing agencies to verify employment. The FECA project in Atlanta certainly demonstrates that this problem exists. Because of the current charge-back system, there

are no incentives for the employing agencies: to verify whether the claimant is receiving income from outside employment; to followup by encouraging the claimant to return to work; and most importantly, to adopt any cost-saving measures.

It is also my concern that there is not any linkage to track what doctors have had their licenses revoked or have been debarred by other programs, such as medicaid, medicare and the State workers' compensation program. We are currently establishing a system that will provide this linkkage. We are coordinating an effort between our office and the Department of Health and Human Services to identify physicians/practitioners, providers and other suppliers of health care services, who have been suspended, excluded or terminated from participation in Government funded medical and benefit programs, such as FECA, medicare and medicaid. Also, a letter is being drafted to establish linkkage with the State workers' compensation programs. This effort, while in the initial stages, will be coordinated with other Inspectors General, to identify fully providers who falsify bill information, submit bills with excessive costs or charges, and furnish excessive or inferior services.

Finally, I wish to note our support for the legislation that Congress is currently considering that will reform the Federal Employees' Compensation Act. It is our view that this legislation will substantially tighten up the program since: It removes incentives for employees to remain beneficiaries after they recover from a work-related illness or injury; it removes disincentives for employees in stay home in instances where the injury is slight; it strengthens the obligations that employing agencies have to submit promptly relevant evidence when employees file a claim for FECA; and it provides stronger administrative tools to reduce waste, fraud, and abuse. We view the passage of legislation to reform FECA as a positive initiative and urge its prompt passage in the Congress.

This concludes my prepared statement. I am prepared to answer questions at this time.

V. Prepared Statement of James E. Bradburn, Special Agent, Office of Special Investigations, USAF

Mr. Chairman and members of the subcommittee: In an effort to curb the costs of the Federal Employees' Compensation Act to the Department of the Air Force, AFOSI has been actively involved in the detection and/or investigation of fraud, waste, and abuse in connection with FECA. We have developed, on our own initiative, a very comprehensive investigation program. This program has been very effective in terms of identifying irregularities, both criminal and administrative, and causing a reduction in expenditures of Air Force funds.

To identify past and present Department of the Air Force civilian employees who are suspected of fraudulently receiving FECA benefits, OSI has employed a technique referred to within OSI as a fraud investigative survey. A fraud investigative survey provides our agents with a step-by-step approach which, when followed, can lead to the detection of fraud or crime detection weaknesses. The specific survey outline—i.e. step-by-step approach—which we currently utilize for FECA investigations, was developed from research and our past exerience with FECA abuse. It has been revised after testing at McClellan Air Force Base, California, and having witnessed the valuable contribution made by a multi-faceted information and services company to a joint agency effort at Atlanta, Ga., and Jacksonville, Fla.

Fundamental to the success of our survey methodology is the necessity of gaining access to files maintained by OWCP. Files maintained by the Air Force are not always complete since claimants often submit papework directly to OWCP. Also, many Air Force installations are not monitoring the status of injured employees after a 1 year period. This is because the Air Force currently drops employees from accountability after 1 year of absence even though the Air Force is charged for compensation costs for as long as the injured employee receives FECA benefits. The DOL Office of the Inspector General (OIG) has provided invaluable assistance by facilitating access to OWCP files.

Our survey approach emphasizes the need to carefully review claimant files. Claimants whose files meet certain criteria and do not meet other—exclusionary—criteria, as well as any claim identified as questionable by Air Force compensation specialists or OWCP claims examiners, are scrutinized further. Checks are also made with State unemployment offices and by a nationwide multi-faceted information and services company under contract with the Air Force

to identify claimants who had undisclosed earnings or were collecting unemployment compensation while receiving compensation for an Air Force job-related injury. Separate criminal investigations are initiated on claimants who have possibly failed to accurately report to OWCP all employment-generated income. AFOSI agents will then interview claimants identified for further scrutiny. Thereafter, agents will have to use their experience and judgment to determine whether the claimants have committed fraud. Material provided to our agents contains suggested investigative steps to surface indicators of fraud which can then be the basis for a separate investigation. We realize our survey approach does not guarantee identification of all FECA fraud; however, the features of FECA, coupled with problems in obtaining financial and medical information, make it extremely difficult to identify those individuals who are committing fraud. Fortunately, we have had a good bit of success with this approach.

The initial survey, which served as a test of our methodology as detailed in the outline, was conducted at the Sacramento Air Logistics Center (SALC), McClellan Air Force Base, California, during September and October 1980. Since we had previously been informed by OWCP that their files could not be utilized for this purpose, the initial records review was confined to documentation on file at the installation Civilian Personnel Office (CPO). The outline criteria were applied by CPO compensation specialists to a total of 876 files, 203 of which were selected for further scrutiny by the AFOSI survey team. Review of these files identified six regarding which investigations were subsequently initiated. Five of these involved suspected false statements as to whether the injury was job-related.

As a result of the AFOSI investigations, three of the claimants were removed from the compensation rolls and returned to their Air Force jobs. A fourth received a medical reevaluation and was offered employment which took into consideration her disability.

The fifth claim involved a third party claim wherein the claimant had not informed OWCP, as required by the FECA, that he had received a $100,000 settlement from an insurance company as a result of his injury. Shortly after initiation of the AFOSI investigation, the claimant reported the settlement to OWCP, AFOSI has been informed that payment made in connection with this claim totaled $63,713. OWCP officials have advised they are attempting to recoup the overpayments made to the claimant. However, AFOSI plans to have the matter referred to the U.S. Attorney for a decision concerning prosecutive merit.

The survey also identified 14 files with administrative deficiencies requiring the attention of the base CPO or OWCP. Examples were: (1) apparent overtreatment by private physicians, (2) inattention, by supervisors, to medical restrictions imposed by physicians, often resulting, subsequently, in more grievous and costly injuries, and (3) failure to detect and/or consider preexisting injuries at the time of employment.

In addition, the survey documented a method, utilized by the medical insurance carrier for the base work force, to abuse the compensation system. The carrier, which is paid full cost for treating civilian employees who receive job-related injuries, has reportedly billed OWCP for treatment of individuals who deny that the injury was job-related. This would allow the carrier to charge the U.S. Government for medical services which otherwise would have been provided pursuant to the carrier's status as an insurer. AFOSI, with the concurrence of the FBI, is continuing to pursue this matter.

During November 1980, AFOSI was invited to participate, with several other Federal agencies, in a joint survey sponsored and directed by the DOL/OIG. The objective was to identify claimants, formerly employed in one of eight southeastern States, who were suspected of having undisclosed earnings. This project was especially helpful to AFOSI since it included two installations with significant numbers of civilian employees, one of which was a large AFLC facility. The methodology employed consisted of a comprehensive review of 260 Air Force files, identified by utilizing an "abuse-prone profile" developed by DOL/OIG, supplemented with inquiries of unemployment insurance records as well as those of a multi-faceted information and services company.

The survey identified 21 files which required substantive investigations by AFOSI due to conflicting information or indications a claimant may not have been completely honest in reporting his/her income or self-employment. Collectively, these claimants were receiving compensation benefits totaling $352,560 per year, excluding medical costs. To date, undisclosed earnings have been documented in four of the cases. These cases will be referred to the U.S. Attorney as a group following coordination with the DOL/OIG.

In addition, this review identified 50 files which appeared to require administrative action by OWCP. Examples of irregularities noted were: (1) work tolerance

exams completed but no action taken by OWCP to assign a "rating" as to what type(s) of employment the claimant was capable of performing, (2) need for an impartial physician's opinion due to conflicting opinions regarding the extent of the claimant's disability, (3) need for current medical examination, due to incomplete previous exams, and (4) reports by physicians that, contrary to the contention of the claimant, the current injury was not a recurrence of previous injury and, therefore, not an allowable claim.

The survey at Wright-Patterson Air Force Base, which includes claims filed at Newark Air Force Station, Ohio, began with a review of 383 records on file at the OWCP regional office in Cleveland, Ohio. A total of 22 potentially fraudulent claims were identified. The circumstances surrounding the filing of the claims, which primarily concern undisclosed earnings, injuries suspected of being non-job-related, excessive charging by physicians, and feigning the continuation of injuries, will be individually pursued upon completion of the survey.

Also included in these 22 files are 5 Third Party claims, which involve compensation and medical payments totaling $413,545.11.

DOL/OIG has discussed these claims with the U.S. Attorney, Dayton, Ohio, who has expressed an interest in being kept apprised of developments as the investigations proceed.

An example of one particularly flagrant abuse of the compensation system which was surfaced during the survey is as follows: An individual who was receiving compensation benefits as a result of a previous injury, submitted claims for medical payments incurred as a result of a non-job-related automobile accident. Included was a claim for a hysterectomy performed following the accident. The file contained a letter from OWCP to the claimant indicating the payment for surgery had been made in error. The letter stated the attending physician had been informed that any such medical treatment not related to the claimant's "accepted condition" was her personal responsibility and not chargeable under FECA. The file reflected no evidence of any attempted recoupment action by OWCP. In addition, a bill totaling $84.00, for television and telephone charges incurred by the claimant during her hospitalization, was not honored. This claim will be the basis for a separate AFOSI investigation.

The survey at the OCALC began with a review of 219 Air Force claims on file at the OWCP regional office in Dallas, Tex. The review resulted in 10 files being categorized as having administrative deficiencies and 4 as having potential for criminal investigation.

The administrative deficiencies were of the following types: (1) failure to request work tolerance letters from physicians to determine if the claimant could return to work, (2) failure to offer the claimant employment even though such action had been approved by the physician, (3) lack of followup concerning unanswered requests for work tolerance letters, (4) lack of independent medical evaluation, and (5) lack of current physician's report. These findings were summarized and coordinated with the OWCP and installation CPO for corrective action.

Included in the potential criminal matters was a possible Third Party claim. The claimant, injured when equipment he was operating collapsed, reportedly collected damages from the manufacturer but failed to notify OWCP.

Also included in the files being further scrutinized was one involving a back injury suffered in 1962. In 1970, the claimant was convicted of armed robbery and sentenced to prison. Although still incarcerated, he continues to receive compensation payments. This matter was coordinated with the Dallas OWCP regional office for a determination as to the appropriateness of the claimant continuing to receive benefits. At this time, the matter remains unresolved. We will followup with DOL/OIG.

AFOSI plans to expand its workers' compensation program beyond these large AFLC installations. We have been informed by the DOL/OIG that they are planning a new joint project which will encompass the remainder of the United States. AFOSI has been invited to participate. Subsequent to this new project, and depending on its scope and results, we will consider surveys in additional Major Commands. During this time, we believe it is essential that we maintain contact with the Air Force Directorate of Manpower and Personnel in order to provide input which could be utilized for policymaking decisions and to assist with their recently instituted bill verification procedure. At the conclusion of the proposed nationwide DOL/OIG-sponsored project, or following additional AFOSI surveys, if appropriate, we will prepare a special report referencing the resultant cost savings and corrective actions. In addition, articles including these findings,

and associated management responsibilities, will be submitted for inclusion in an Air Force Inspector General publication. We also plan to continue to make releases through Air Force Public Affairs offices in order to maximize coverage of our efforts in Air Force newspapers and other publications. Finally, in an attempt to sensitize all AFOSI agents to the importance of fraud in this area, as well as to familiarize them with the claim filing process, its susceptibility to fraud, and methods of detecting attempts to defraud the program, copies of our workers' compensation survey outline have been distributed to all AFOSI regional field offices.

There is much that the Air Force can do to improve the effectiveness and administration of the Air Force injury compensation program. The auditors who prepared the audit report on injury compensation policy and operation expressed the belief that the opportunity exists to restrain the spiralling costs of FECA through adopting a more structured approach to managing the injury compensation program. The auditors identified several areas which they believed afforded the greatest opportunity for reducing costs. Many of the areas identified by the auditors as affording the greatest opportunity for reducing cost would probably result in a substantial cost reduction. By way of example, the experience of the Postal Service, referred to in the AFAA report, indicates that establishment of a rehabilitation program and improved procedures for assigning individuals to light-duty positions represent the best opportunities to reduce costs. For the program to work, in many instances, Air Force employees should be retained on the employment rolls even after 1 year of absence, as has been recommended by the Office of Personnel Management. We are encouraged by the written response of management to the Air Force audit report.

The 1974 amendment to FECA liberalized the law and made it easier for individuals to receive FECA benefits. While we readily acknowledge that the government should have a program to compensate those who are injured on the job, there should be some waiting period prior to the claimant receiving any monetary compensation benefits including the agency-paid continuation of pay. Therefore, we are of the opinion that if the 3-day waiting period were reinstituted before any monetary compensation benefits were paid to the claimant, it would reduce the temptation to commit fraud. We also believe the employing agency should be given the option of having the injured employee periodically examined by an agency-identified physician. We believe the injured employee should be given the right to select his/her own physician. On the other hand, we believe that by having an agency-identified physician examine the claimant, the employing agency can protect itself from any deceitfulness by the two parties—claimant and claimant's physician—who have a financial stake in the continuance of the compensation.

We believe OWCP, as the chief program administrator, should give serious consideration to becoming more actively involved in the detection of fraud and elimination of waste and abuse. For example, OWCP might help identify potentially fraudulent claims by developing an abuse prone profile. The identity of the claimants meeting the elements of the abuse prone profile might be provided to both the DOL/OIG and the investigative agency servicing the employing agency. OWCP also should give serious consideration to tightening up administration of claims when third party involvement is apparent. The aforementioned AFAA audit noted also that OWCP had approved claims which included compensation for physical loss that existed prior to initial employment. We share the auditor's opinion that the intent of the law is to provide compensation for only that portion of the loss that occurred after initial employment with the Air Force. Finally, we strongly urge that consideration be given to amending FECA to provide the employing agency a right to appeal, or to obtain OWCP reconsideration of, initial OWCP decisions. Such changes will provide some checks and balances which would better serve the interests of the employing agency and the taxpayers of this country.

Thank you for the opportunity to address this distinguished committee on this very important issue.

VI. Prepared Statement by Morris B. Silverstein, Deputy Inspector General, Office of Inspector General, Veterans' Administration

Mr. Chairman and members of the committee: I am pleased to be with you today to discuss the Veterans' Administration Inspector General's participation with the U.S. Department of Labor Inspector General's Office in a project to identify recipients of benefits under FECA—Federal Employees' Compensation

Act—who have filed false statements concerning income with the Office of Workers' Compensation, U.S. Department of Labor.

The costs incurred by the Veterans' Administration for unemployment compensation payments to their employees and former employees under the Federal Employees' Compensation Act were $32,547,717 in fiscal year 1978, $38,685,180 in fiscal year 1979, and $42,486,196 in fiscal year 1980. Although we have had few indicators in the past regarding the existence of fraud and abuse in FECA benefits paid VA employees, we share the subcommittee's concern regarding the possible existence of fraud and abuse in this program.

When we were initially approached in mid-1980 by representatives of the Department of Labor Inspector General's staff to participate in a pilot project in the eight-state Atlanta region to identify recipients of fraudulent benefits under the Federal Employees Compensation Act of 1974, we welcomed the opportunity to determine whether funds were being fraudulently obtained by former VA employees. We readily agreed to participate in the project and commenced field work in the Atlanta region in November 1980.

The selection criteria used by the Department of Labor to identify claimant files for review were as follows:

(a) Total compensation for the year specified equaled $6,000 or more.
(b) The injury was not fatal.
(c) The period of compensation was 2 years or greater.
(d) The claimant had no loss of wage earning capacity.
(e) The claimant's age at the date of injury was 55 years or less.

The files of 173 VA claimants were selected using these criteria for a small number of employees. Additionally, employment information was obtained for comparison purposes from State unemployment agencies and from a private credit corporation. Of the 173 files selected, 164 were available for review. Of these, seven cases contained indicators of possible fraud. However, subsequent investigation discolsed no evidence of fraud on the part of claimant or medical service providers in any of these cases.

Review of the 164 available files determined that 80 of them did not disclose any information indicating failure to report employment or discrepancies requiring action by office of workers compensation program.

We were disturbed to find, however, that of the 164 files available for review, 77 contained information indicating possible administrative shortcomings on the part of the Department of Labor which allowed questionable payments to be made to VA claimants. Examples of these were: (1) no action taken when a claimant failed to respond to requests for information: (2) failure to require timely medical evaluations when appropriate; (3) no aciton taken to resolve significant conflicting information contained in files; (4) no action taken when medical information in the files suggested claimants could work; (5) no action taken to verify claimed dependents when questionable; (6) failure to take action on cases which indicated medical treatment payments for problems unrelated to the job injury, and (7) no action taken when there were indicators of excessive medical treatment.

One interesting case involved an attorney who was receiving Federal Employees' Compensation Act payments since 1972. This claimant, who received his law degree in 1975 under the Federal Employees' Compensation Act vocational training program, operated two separate law firms during much of the period he was receiving FECA payments. He was also a special counsel for a congressional committee part of this time receiving an annual salary of $34,500. By reporting much of his income as a bonus rather than straight income, the attorney took advantage of a FECA loophole which rules that a bonus cannot be used in making an income determination. The attorney reported his income in such a manner as to be confusing to employees of office of workers compensation program. His compensation has now been terminated.

Another case involved a claimant injured in July 1972 lifting a 4-ounce salt shaker. An August 21, 1972 letter from the patient's doctor indicated a preexisting back problem however the witnesses indicated a shoulder injury and not a back problem. In March 1973, the doctor indicated a 10 percent disability.

A third instance involved a 1980 letter from a doctor indicating the patient could not lift her children with her right arm. The children according to the file were 15, 20 and 22 years old.

In another instance, the file contained letters from doctors in 1977, 1978, and 1980, all indicating that the claimant can work.

In yet another case, the last medical information in the file was dated in 1973, and indicated the claimant could work and there was nothing wrong with him.

In each of these cases the claimants continued to receive payments and we have not yet been advised of actions on the last 4 cases mentioned above.

All 77 of the cases indicating possible administrative shortcomings on the part of the Department of Labor were referred to the Office of Workers' Compensation through the Office of Inspector General, Department of Labor for appropriate action. To date, office of workers' compensation has either terminated or reduced compensation being paid to former VA employees on 11 of the referred cases.

The monthly savings to the government as a result of reduced or terminated payments to these former employees alone is $6,880 per month or more than $80,000 per year. The actual savings should be greatly increased since these 11 employees would have presumably received payments for several years in the future.

The U.S. Department of Labor has indicated that action is still pending on 66 of the cases referred to them and we anticipate significant additional savings when the actions are completed.

Cooperation by the U.S. Department of Labor program officials during the course of this project was good; however, we have experienced some difficulty in obtaining timely action from them on the remaining 66 cases referred to them. For example, we informed the U.S. Department of Labor of the results of our review and referred the 77 cases for administrative action in December 1980. However, it was not until June 1981 that we were informed of the action taken on the 11 cases which we previously referred. We understand that additional cases will be reported to us in the near future.

I am ready to respond to any questions that you may have.

VII. Prepared Statement of Ralph M. Hartman, Director of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor

Mr. Chairman and members of the subcommittee: I appreciate this opportunity to appear before your subcommittee today to discuss our efforts to reduce fraud and abuse under the Federal Employees' Compensation Act (FECA) program.

At the outset, I want to assure you and the members of this subcommittee that the Department of Labor is committed to improving the performance of the Federal Employees' Compensation program. Within the Employment Standards Administration (ESA), the three Federal workers' compensation programs administered by ESA, and in particular FECA, are receiving the highest priority for resources and development of sound management and control systems.

This subcommittee is well aware that the FECA in past years has been beset by serious deficiencies in the administration and management of the program. As a result, the program has had a high potential for misuse, abuse, and fraud by both claimants and treating physicians. Program deficiencies have been documented in the host of internal and external investigations of the FECA program that have been conducted in recent years. These reports generally reached the same conclusions as to these deficiencies. They included the lack of effective claims management and processing procedures, the lack of adequate medical standards for claims determinations and subsequent monitoring and quality control of those claims determinations.

It is only in recent years that these deficiencies have received the kind of attention needed to turn the complex and broad program around. The establishment of the Office of Workers' Compensation Task Force in 1976, the subsequent increases in staff resources and the implementation of substantial automated support systems have contributed to a very significant series of improvements in the operations and service delivery of the FECA program. As a result of these efforts, we have now reached a point where we can focus on the day-to-day management of the program and the institutionalization of program improvements rather than on constant firefighting which previously characterized the FECA program. We are thus in a position where the prevention and rooting out of waste, fraud and abuse can and will receive the close attention on a day-to-day basis that they deserve.

I assure this subcommittee that we share its concern that waste, fraud, and abuse should be eliminated from the FECA program. Long-term disability cases must be continually monitored to ensure that injured workers remain on FECA rolls no longer than necessary and that workers are encouraged to seek rehabilitation and reemployment. We, too, are concerned, that some physicians have

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used unethical, if not illegal, means to overtreat and overcharge disabled Federal employees. This in no way should be viewed as a broad indictment of the medical community. The overwhelming majority of medical providers are fair and ethical in their dealings with injured Federal workers and OWCP. But we are committed to preventing, and prosecuting if necessary, illegal and unethical medical practice as it affects FECA. We are committed to working closely with the subcommittee to reduce the vulnerability of the FECA program to such abuse and fraud by both injured employees and those who provide medical and related treatment.

I would like to describe some of the actions taken to address the areas of fraud vulnerability of particular concern to this Subcommittee as noted in the invitation to the Department of Labor to testify at this hearing.

MONITORING OF PERIODIC ROLL AND QUALITY CONTROL

The most effective way to protect the integrity and prevent abuse and misuse of the FECA claims process is to ensure that OWCP claims decisions in the first place are based on the best evidence available, and that such determinations are made by highly qualified personnel. The FECA program has in place a strong monitoring and quality control program. For the past 3 years, we have had an intensive training program for both experienced and newly hired claims examiners. A well-trained staff is crucial to an effective workers' compensation program.

The subcommittee's concern that the Office of Workers' Compensation Programs (OWCP) actively monitor periodic payments to disabled workers is being vigorously addressed. We believe that a major step toward quality control has been the increased scrutiny of the long-term disability payment rolls. All cases on the long-term disability roll are reviewed on at least an annual basis and oftentimes more frequently according to standards and procedures established by the OWCP National Office. This systematic review has developed over the past 3 years. In fiscal year 1980, nearly 56,000 cases were reviewed. This review resulted in the removal of about 2,000 cases and the downward adjustment of benefits in nearly 3,000 other cases. The estimated savings for fiscal year 1980 alone were nearly $17 million. Of course, the impact of reducing benefits or removing a case will be felt in future years as well, so that actual savings go far beyond the fiscal year in which they are initiated.

Through the first 9 months of fiscal year 1981, over 41,000 cases had been reviewed, resulting in the removal of about 2,000 cases from the periodic roll and the downward adjustment of benefits in over 16,000 other cases. The estimated annual savings for fiscal year 1981 resulting from periodic roll case reviews conducted during the first three quarters will total $21 million. As we continue to increase the quality of our periodic case review and initial claims determinations, we expect less dramatic adjustments in benefits to cases on the periodic roll.

We believe that an active investigation program to verify the continuing disability of claimants is another key element in efforts to reduce fraud or abuse. Permitting workers to benefit improperly from erroneously approved claims or continuing benefit payments to employees whose conditions no longer warrant further benefits, is wasteful and has corrosive effects on employee morale. We have recently implemented a nationwide joint OWCP/Wage and Hour Division investigation program aimed at updating and verifying the continued disability of workers receiving FECA benefits. This effort will lay the foundation for an effective internal investigation capacity. This joint investigation program evolved out of a pilot program in the Boston Regional Office of ESA.

We conducted 38 investigations under this pilot program. As a result of these investigations, the OWCP has been able to make significant reductions in the amount of monthly compensation paid to 19 claimants that reflect improvements in their medical conditions. Six employees were deemed fully recovered and removed from the payment rolls. Total annual reductions in benefits for these employees will approach $243,000. Based on life expectancy, we estimate that these reductions will eventually result in a savings of about $4.3 million to the Federal Government in the form of lower compensation payments.

This increased emphasis on the investigation of claims and the publicizing of these results will help to insure that existing and future claims for compensation are valid, and that potential misuses, abuses and fraud are curtailed. At the same time we intend to fully protect the legitimate rights of claimants who have valid claims.

OWCP's anti-fraud efforts that have been in place for the last 3 years also serve to protect the integrity of the FECA process. This program is now the responsibility of the Office of the Inspector General which investigates allegations of fraud and abuse in all programs administered by the Department of Labor. We have been informed by the Office of the Inspector General that the increased emphasis on investigating cases of suspected fraud under the FECA has begun to produce results. During the October 1, 1980 through July 1981 period, the Inspector General opened 143 potential criminal cases in the workers' compensation area. During this same period, 47 cases involving FECA-related violations were referred to the United States Attorneys for criminal prosecution, resulting in 11 indictments and 8 convictions. We have worked closely with the Office of the Inspector General in all of these cases.

Now, let me respond to the specific concerns enumerated in your letter of invitation.

A. QUALITY OF BILL PAYMENT AND TRAINING OF PAYMENT CLERKS

The medical bill payment function is another area of concern to the Department. We have made substantial improvements in this area in recent years. Prior to 1978, the bill payment function was an entirely manual operation. At that time, it took on average 71 days to pay medical service bills. This meant that routinely District Offices would receive two or more submissions of the same bill for medical services since we were unable to make payment before more than two billing cycles passed. The operational impact of this exaggerated and unnecessary mail volume was, of course, severe. For example, about 757,000 medical bills were received in fiscal year 1980 alone. However, the greatest potential problem in the routine receipt of multiple versions of the same bills was the impact on the efficiency, quality, and integrity of bill payment operations. At least twice as many bills had to be processed, half of which were duplicates, all in a completely manual system, creating substantial opportunity for fraud and abuse.

Our major efforts have been directed at reducing the time required to pay bills to within one provider billing cycle—about a month—while at the same time improving the scrutiny and overall quality of bill payment decisionmaking by our benefit payments clerks. By making payments within one billing cycle, the number of duplicate payments are reduced, thereby reducing the potential for fraud and abuse. The achievement of this ambitious one-cycle payment goal has been largely accomplished. We now routinely pay more than 76 percent of payable bills within 28 days of receipt.

We realize that quality must not be sacrified in efforts to reduce average bill payment time. We are working closely with personnel specialists to upgrade the benefits payment clerk position to take into account the considerable responsibilities involved. They are responsible for making payments for bills and compensation totalling millions of dollars—about $2 to $3 million a month in the New York district office alone. They are required to make decisions as to reasonableness of charges and the appropriateness of medical services in relation to the compensable medical condition in accordance with established procedures.

Our benefits payment clerks need formal training to supplement the on-the-job training that they now receive. We are now in the early stages of developing such a program. We have already taken steps in the larger district offices, where it has been a particular problem, to increase the ratio of supervision to benefits payment clerks. We believe that these steps are necessary to assure quality decisionmaking until the more sophisticated automatic data processing system (Level II) is in place. This replacement system will greatly extend the scope of computer support for decisionmaking in the bill payment operation. It will also provide more comprehensive data on the reasonableness of medical charges.

B. MEDICAL PROGRAM EFFECTIVENESS

We have also begun to place increased attention on strengthening our medical program to assist claims examiners in making increasingly more difficult decisions based on complex medical evidence. As this subcommittee is well aware, the FECA program, which was designed initially to compensate workers for lost wages due to acute traumatic injuries, must now process a significant number of claims involving occupational disease. Claims involving occupational

disease accounted for about a fourth of all claims filed last year. To meet a long-time need as well as the challenge posed by nontraumatic claims, a division of medical services and standards has been established.

In an effort to further increase the medical resources available to claims examiners, the Department's fiscal year 1982 budget submission requests 20 full-time permanent medical positions to assist the district medical director in each district office. The additional positions will permit medical personnel to devote more attention to training claims examiners and educating physicians as to important medical concepts under the FECA. In addition, the program has made extensive use of consulting medical specialists to assist claims examiners in complex medical determinations. For example, we have used pulmonary impairment specialists as consultants in those areas with the highest concentration of asbestosis-related claims so that curative medical treatment may be instituted to reduce the period of disability.

The division of medical services and standards has developed and implemented a number of medical guidelines to facilitate claims development and adjudication, to provide technical and expert information, and to assure the provision of quality medical care to injured workers. In addition, the division has been developing guidelines which will serve to improve medical decisionmaking and treatment in the areas of lower back injuries, stress, and radiation-related injuries.

We are particularly encouraged by the initial results of the lower back pilot project. Lower-back injuries accounted for about one-fifth of all claims filed last year. Under a pilot project, participating agencies and especially the Postal Service are requested to refer to OWCP any claimant who has been, or is likely to be, out of work for 30 days due to an alleged lower back injury. The claimant is then quickly referred to a consulting orthopedic surgeon or neurosurgeon. This process assures that the injured worker receives proper and timely medical treatment to speed recovery and return to gainful employment. A by-product of this effort is a substantial reduction of the potential for abuse.

C. MEDICAL FEE COST CONTAINMENT EFFORTS

Under section 8103 of the FECA, the Department is required to pay all "reasonable" charges for medical services and appliances related to the compensable medical condition. Prior to recent improvements in bill payment functions and the utilization of limited ADP techniques, we had little control over the "reasonablness" of medical payments. Quite frankly, we are still not fully satisfied with present cost containment procedures. The ADP capability now in effect provides dollar ceiling limits based on provider type (e.g., physician, hospital pharmacy, etc.). We require that prior authorization be obtained for charges that exceed those limits. In addition, our procedure manual recommends use of State workers' compensation schedules as guides for determining reasonableness of fee charges.

We are aware that the present guidelines are of limited effectiveness and that guidelines for specific services are necessary. The more sophisticated ADP replacement system will meet this need. The use of "usual and customary" fee schedules is an integral part of the design of the replacement ADP system which will be fully operational by fiscal year 1984.

D. COLLECTION OF INFORMATION ON QUESTIONABLE MEDICIAL PROVIDERS

Let me briefly describe some of the means by which we gather information on "questionable" medical providers. The claims review process is the most effective means to uncover questionable medical proivders. However, we are also developing data analysis procedures for identifying patterns of potential questionable practices. We expect our ADP system to be producing the necessary reports by October 1, 1981.

We realize that the maintenance of effective channels of communication with local medical associations and investigative bodies such as this subcommittee is a vital element in our overall efforts to gather information on questionable medical providers. For example, we are increasing our contacts with local medical associations to obtain the names of doctors who have been convicted of fraud or have had their licenses revoked, suspended, or reinstated. Upon receipt of this information, the physician's past and present dealings with OWCP will be closely scrutinized to determine any abuse or apparent fraudulent practices. Necessary administrative action either through OIG or OWCP will be taken,

including consideration of whether future bills submitted by the physician will be paid.

E. MONITORING AND VERIFICATION OF MEDICAL SERVICES

We plan to expand our role in monitoring the medical treatment provided injured employees—not only from the standpoint of cost but also quality. This subcommittee is well aware that some physicians providing treatment to injured workers have taken advantage of injured Federal employees and the taxpayers, who ultimately bear the costs of FECA, by billing OWCP for medical services not actually performed.

The newly installed medical verification reporting system will go a long way toward reducing loss due to payment for medical services not actually performed by medical providers. The OWCP will soon provide claimants with reports listing all medical services for which we have been billed on their behalf. The claimants will be requested to verify that the services were provided and whether these have been otherwise paid. This will reduce the loss due to payment for services not actually performed by treating medical providers.

F. METHODS TO DISQUALIFY OR EXCLUDE QUESTIONABLE MEDICAL PROVIDERS

We do not currently have in place a mechanism to disqualify questionable medical providers or to exclude such providers from participation in the FECA program. However, we will soon be issuing instructions to all claims personnel describing what are considered to be questionable practices and the steps to be taken in processing claims involving such practices. Questionable practices include overcharging, charging for treatment not provided, unsatisfactory medical reporting, and overextended or unnecessary treatment. Our objective is to establish an administrative procedure that will enable FECA to avoid the use of physicians who engage in questionable practices, and to "deauthorize" such physicians from examining and treating claimants in connection with FECA. Any medical report submitted by a "deauthorized" physician will not be considered as meeting requirements for medical evidence necessary to adjudicate a claim.

We also have underway a number of specialized efforts which will help to reduce loss vulnerability of the FECA program. We have taken steps to reduce the potential for profiting from the improper use of multiple employer identification numbers (EIN) issued by the Internal Revenue Service (IRS). Some physicians use more than one EIN mostly for legitimate business purposes. The physician may have an EIN for himself, another for a partnership, and possibly a third for a professional corporation. However, this practice creates serious difficulties for an ADP system. Since the system enters the EIN as the primary identifier, if a physician uses more than one without OWCP's knowledge, a proper control may not be kept on the physician's billings. Some unscrupulous physicians may have used or are using multiple EINs purposely to make it difficult for payment systems, such as those used by FECA, to track accurately billings by these physicians.

We have explored with IRS the possibility of matching the contents of our EIN/Provider files to that agency's files for validation. We have been informed by IRS that its files can only be used to validate whether an EIN was within a range of valid numbers and not whether this number was assigned to a bona fide medical provider or whether this was the only such number assigned. We will continue to work with IRS to explore ways to deal with this complex problem.

In conclusion, I want to reassure this subcommittee that we are committed to the elimination of waste and fraud in the FECA program and for improving services for injured employees and Federal employing agencies alike.

Thank you again for this opportunity to comment on these matters. My colleagues and I will be happy to answer any questions you may have.

VIII. PREPARED STATEMENT OF KENNETH T. BLAYLOCK, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

The American Federation of Government Employees, AFL–CIO, is pleased to have the opportunity to appear and testify on the subject of fraud and abuse in the Federal employees workers compensation program. AFGE represents over 700,000 Federal personnel in most agencies of the executive branch and the topic of these hearings is of vital relevance to them. We are very pleased that

the Senate, unlike the House of Representatives, is holding hearings to examine the problems with the workers compensation program so that well-designed and equitable reforms can be implemented.

Let me comment at the outset that the overriding goal of the subcommittee—the elimination of fraud and abuse in FECA—is certainly one which we wholeheartedly support. We have testified before Congress on several previous occasions to the effect that if steps were not taken by the Department of Labor to implement fundamental administrative reforms in the FECA program, the day would come when Congress would step in and attempt to cut costs by trimming back benefits and tightening eligibility criteria. In short, all Federal employees would be forced to suffer for the program abuses committed by a tiny minority of claimants who have attempted to take advantage of the system.

Unfortunately, the fears of AFGE and other AFL–CIO affiliated unions which represent personnel in the Federal Government appear to have come true. The House of Representatives this year is proposing radical and far-reaching changes to the FECA program—changes which will indeed save money, but do little to preserve the principles of equity and fairness to the employee which were achieved back in 1974 when the present system was established.

The House makes the following recommendations:

No. 1. Removal of continuation-of-pay provision which allows disabled or injured employees to be compensated by their agency for up to 45 days while their claim is being processed. This is most unfair because there are lengthy delays in the processing of most claims.

No. 2. Change the basis of computation of disability benefits from 66⅔ percent and 75 percent of base pay to 80 percent of predisability spendable income. Benefits would be taxable. We believe a more equitable payment formula, which would also result in substantial savings, can be developed. Also, benefits should retain the present tax-exempt status.

No. 3. There would be a seven day waiting period; with 5 days eliminated if disability extends beyond 14 days. The remaining 2 days—or all 7—would be chargeable to leave or advanced leave. In short, the employee would be penalized by loss of leave for short-term injuries caused by unsafe and unhealthy working conditions.

No. 4. Convert disability beneficiaries at age 65 to civil service retirement rolls. This proposal is inconsistent with the basic philosophy of workers compensation, and would completely change the nature of the program.

No. 5. There would be changes in the schedule award provisions and in death benefits with a social security offset. The offset provision is patently unfair because it removes added income based on the survivor's earnings and/or decedent's non-Federal earnings.

No. 6. All these changes would apply retroactively to all current and future beneficiaries. The standard of living of these personnel and their families would substantially decline.

AFGE only hopes that as Congress makes the final decisions on the fiscal year 1982 Budget, there will be some effort to limit the potential damage to the incomes of disabled and injured Federal personnel who now qualify for FECA benefits and who have never cheated the taxpayer.

AFGE would prefer to focus attention on ways in which the dramatic rise in FECA costs can be slowed without penalizing the 99 percent of Federal workers who have not and will not attempt to abuse the program.

First, it is important to remember that the most effective way to reduce FECA program costs is to make the Federal Government a safer place in which to work. This observation may seem trite, but it happens to be very relevant for the deliberations of this subcommittee. For example, I would like to draw your attention to the situation at Hill Air Force Base in Ogden, Utah, where it is estimated that over 100 Federal personnel have died over a period of several years from working with powerful solvents and other chemicals with noxious side effects. Hundreds of other employees may have suffered lasting damage to their health. The Senate Labor and Human Resources Committee recently held on-site hearings which did much to focus public attention on the issue. We mention this because in the past the Federal Government, as an employer, has been a follower rather than a leader in the field of health and safety, and there are some disturbing signs that the situation may grow worse under the current administration. As long as executive branch agencies do not take seriously their responsibilities under Executive Order No. 12196 to eliminate potential health hazards from the Federal workplace, it can only be anticipated that the growth in the FECA rolls will continue to swell and costs will continue to rise.

In short, as long as Federal OSHA programs remain woefully deficient, AFGE believes the administration and Congress have an ongoing responsibility to ensure that the Federal workers compensation program is well-managed, efficiently run, and free from exploitation or fraud by physicians, health care providers, or claimants.

Second, we understand that this subcommittee has had an ongoing investigation into fraud and abuse in the FECA program which has focused on two specific problems: (1) the extent to which physicians have claimed and been reimbursed by OWCP for services which were never rendered to FECA recipients; and (2) the existence of a substantial number of supposedly disabled employees who collect benefits long after they have recovered and, in some instances, taken other jobs.

AFGE would like to emphasize that if the Subcommittee has found a pattern of abuse by some FECA recipients and medical providers, then Congress should immediately put the Department of Labor on notice that such practices will not be tolerated.

It comes as no surprise, however, that given the current state of chaos in the FECA claims processing system that such problems continue to surface. In May, 1980 AFGE testified in detail before the House Education and Labor Committee about the chronic staff shortages in the OWCP that have led to record delays in claims processing, as well as to record levels of program abuse. We pointed out that in the absence of sufficient numbers of qualified claims examiners it could only be anticipated that fraudulent claims would be filed and approved. The OWCP simply lacked the resources to adequately police the system.

At that time, AFGE made a recommendation which we believe deserved serious consideration by this subcommittee if it wishes to solve the two prob'ems identified above. First, the OWCP should institute procedures for the rapid processing of FECA claims and streamline the existing complex and expensive claims review and appeals process.

This could be done by giving the OWCP's district offices additional authority to make initial recommendations on claims. Specifically, in those instances where the physician selected by the employee and the OWCP physician agree as to the nature of the injury or illness, the claim would then go immediately to a district-level review panel to decide the question of whether or not the injury was job related. If the review panel decides this issue in the affirmative, then the matter would be resolved and benefits would be paid to the employee. Presently, the OWCP in most cases fails to obtain a second medical opinion from a physician, and the case processing may drag on for months or years until a medical examiner is able to find and review the file so a determination can be made.

In those instances where the examining physicians fail to agree, or where there is a dispute on the job-relatedness nature of the injury, then the appeal would go to a regional OWCP office for review.

AFGE believes that as much as 80 percent of the FECA caseload could be resolved at the district OWCP office through this rapid processing system. A substantial amount of the enormous paperwork burden that now clogs up the higher OWCP channels would be eliminated. The regional OWCP offices could then focus their energy in ferreting our fraud and abuse in the program. We remind the subcommittee that the Secretary of Labor has full legal authority to contravene any spurious claim.

Further, AFGE believes that Federal agencies have failed to meet their responsibilities to implement programs to retain and place disabled or injured employees who may not be able to return to their original jobs, but who may still be able to assume other duties. AFGE has never been able to comprehend why the Federal Government can devote considerable resources to training new personnel, but has never made much of a commitment to the reemployment of employees who have been injured on the job.

In conclusion, we would like to make 5 specific recommendations for reform of the Federal workers compensation program:

No. 1. The Department of Labor should be required, at one or more district OWCP offices, to set up a pilot program to test the practicality of system for the rapid processing of claims based on a second medical opinion by the OWCP physician.

No. 2. The Department of Labor should issue regulations prohibiting payments by OWCP to physicians who have been found to have committed fraud in government programs like medicare and medicaid.

No. 3. The Department of Labor should develop a "fee schedule" individually suited for regional offices to determine whether medical or hospital charges are reasonable.

No. 4. Federal agencies should immediately implement a retraining and placement program for FECA beneficiaries who are able to return to another job. It is possible that some sort of bonus or incentive system could be developed for employees and/or personnel officers.

No. 5. The patient and the physician should both be required to sign a form validating the diagnosis and recommended course of treatment.

IX. Questions Submitted by Senator Roth to Mr. Donovan and Answers Thereto

U.S. Senate,
Committee on Governmental Affairs,
Senate Permanent Subcommittee on Investigations,
Washington, D.C., August 3, 1981.

Hon. Raymond J. Donovan,
Secretary of Labor,
U.S. Department of Labor,
Washington, D.C.

Dear Mr. Secretary: During the course of the Permanent Subcommittee on Investigations' July 22 and 23, 1981 hearings on fraud and abuse in the federal workers' compensation program, I indicated that, due to time constraints, the Subcommittee was not able to fully explore certain issues relating to the Department of Labor's role in the program. It was decided that the Subcommittee would request written responses to follow-up questions. Accordingly, I would appreciate your attention to the following. The Department's responses will be inserted in the record of our hearings.

1. *Exclusion and Debarment of Convicted Medical Service Providers.*—Please state whether the Department of Labor, under current law and regulations, has the authority to exclude or deny medical service providers from participation in the federal workers' compensation program based upon:

a. The indictment and/or conviction of the provider for a criminal offense related to services provided under FECA, a state or federal medical program, or some offense indicative of lack of professional integrity.

b. The administrative action taken against a medical provider in accordance with the procedures set forth in 42 USC § 1320 c–9 (b) (Medicare/Medicaid) or 42 USC § 1395y (d) (Secretary's refusal to pay).

c. The exclusion of a medical service provider from participation in a state workers' compensation program.

d. The determination by the Secretary of Labor that a medical service provider:

1. Has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment;

2. Has submitted or caused to submit, bills or requests for payment for services rendered which the Secretary finds to be substantially in excess of such person's customary charges for such services, unless the Secretary finds there is good cause for such bills or requests which contain such charges; or

3. Has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.

Please be advised that representatives of the Department of Labor testified that such a debarment/exclusion system had never been formally proposed at the Department of Labor. Furthermore, the Department of Labor witnesses speculated that such a system could not be developed under current regulatory authority and would require new legislation. Please contrast this opinion with the federal procurement debarment and suspension system, the authority for which exists entirely by regulation. (41 CFR § 1–1.6)

2. *Medical Cost Containment.*—The Department of Labor officials testified that only reasonable medical costs would be paid under the FECA program and that all district offices utilized state workers' compensation fee schedules to determine reasonable costs. It was also stated that current automated data processing (ADP) capability created a ceiling limit on payments to medical service providers. Finally it was represented that a usual, customary and reasonable fee schedule would be an integral part of a new ADP system by Fiscal Year 1984.

a. Identify all district offices that have and utilize fee schedules. Please provide a copy of all fee schedules currently utilized by such districts.

b. Identify, by district, what dollar ceiling limits are currently being utilized in the approval of medical service provider bills, under present ADP bill payment procedures.

c. Identify the bill paying authority of bill paying clerks in each district office.

3. *Boston Pilot Project.*—Testimony was presented indicating that OWCP has had great success in conducting workers' compensation verification investigations using Wage and Hour Division investigators and that the Boston Project is being expanded. Subcommittee investigation indicates that such expansion may be minimal, such as the commitment of only one man-year per region. Please identify the full extent of the planned expansion of the Boston Project on a regional basis.

4. *Medical Program Effectiveness.*—Testimony was presented which stressed OWCP's commitment to utilize medical resources in the evaluation of claims and in examining and approving medical bills. The role of the Division of Medical Services and Standards was stressed in providing guidelines to district offices.

a. Please identify, as of July 23, 1981:

1. How many district Medical Director positions are authorized for OWCP and which districts actually have a full-time Medical Director. (Identify which of these districts have a director who works full-time during normal duty hours.)

2. Which districts have a part-time Medical Director.

3. Which districts have no part or full-time Medical Director.

b. Please identify as of July 23, 1981:

1. How many medical positions are authorized for the Division of Medical Services and Standards, and how many of these positions are filled.

2. Please provide copies of all medical guidelines developed by the Division of Medical Services and Standards.

5. *Atlanta Project.*—Department of Labor officials testified that OWCP fully supported the Inspector General's Atlanta Project and that a written directive had been issued directing district officials to cooperate with investigators from other agencies who wished to gain access to the claims files of the employees of their respective agencies. Testimony was also received from law enforcement officials from other agencies indicating that the Department of Labor was slow in conducting the administrative follow-up of the results of the project. Please provide detailed information regarding the number of cases referred to the Department of Labor for administrative review, the number of cases reviewed to date, the anticipated completion date of the review and the results of the review to date, including an identification of the number of claimants removed, the number of claimants who will receive a reduction in benefits, and the anticipated cost savings from the review. Also please provide a copy of Mr. Hartman's written directive concerning law enforcement access to district office claims files.

6. *Training of OWCP Employees.*—Department of Labor officials testified that an extensive training program had been developed and implemented for claims examiners and that a training program was being developed for bill paying clerks.

a. Identify the number of claims examiners who have attended the training program and the time period that the training program has been utilized.

b. Identify whether the training is provided by national office or district office personnel. If district office personnel provide the training, describe the coordination of such training by the national office.

c. When will the bill paying clerk training program be operational?

7. *Periodic Role Review.*—Department of Labor officials have stressed the success of the periodic role annual review. Testimony was presented which indicated that in the last year and a half, over 90,000 claims files have been reviewed by OWCP employees. If the periodic role review has been so thorough, can you say why the cases discovered by the Subcommittee staff and by the participants in the Atlanta project failed to be detected by the annual review process?

8. *Quality of District Offices.*—Testimony was presented by Department of Labor officials that the New York district office was not among OWCP's "leading performers", in terms of management. Identify which districts are the best and which districts are the worst in terms of claims management.

9. *OWCP Personnel.*—Department of Labor officials indicated that personnel shortages are partially responsible for poor management practices. Identify, as of July 23, 1981, the number of claims examiners, supervisory claims examin-

ers, bill paying clerks and medical personnel who are authorized and the number who are on board.

10. *Identification of Questionable Medical Provider Practices.*—Department of Labor officials testified that an ADP system was being developed to identify patterns of questionable practices. Such a system is to be in effect by October 1, 1981. Please provide additional details regarding this system.

11. *Verification of Medical Services.*—In February 1981, the Inspector General recommended that OWCP provide FECA claimants with a statement which would set forth all medical services which had been paid under their claim, and would require the claimant to verify these services with OWCP. This would alert the claimant and the Department of Labor to any false billings by the medical service provider. Department of Labor officials testified that such a system would be implemented soon. Please set forth full details of OWCP's plans to implement this program and state when this system will go into effect.

12. *OWCP Acceptance of Photocopies.*—Department of Labor officials informed the Office of Inspector General in October 1980, that procedures were being revised to preclude the acceptance of the photocopies of medical bills. Please describe when such procedures will be developed and when they will be implemented. If photocopies are still being accepted, please justify and identify those district offices which are accepting photocopies.

13. *Employer Identification Number (EIN) Verification.*—Department of Labor officials testified that present discussions with the Internal Revenue Service (IRS) have not resulted in a satisfactory resolution regarding verification of medical provider EINs. If the Department of Labor cannot resolve this problem promptly, what plans have been considered to utilize a different identifier, other than the EIN? What offices at IRS have been contacted regarding this problem and what was the date of the most recent contact. Please provide copies of all correspondence between the Department of Labor and the Internal Revenue Service regarding this matter.

14. *Bill Rejection by New York District Office.*—Department of Labor officials testified that the New York office had rejected 13,000 bills totaling over $1 million. Please provide additional information regarding these bill rejections.

Your prompt response to these questions by August 17, 1981 will be greatly appreciated. As I indicated at the hearings, the Subcommittee is most concerned with the Department of Labor's management of the FECA program. We plan to hold additional hearings, whenever such hearings may be appropriate to ensure that the Department of Labor has been responsive to our concerns. I am certain that you share these concerns and that appropriate resources will be committed to addressing them as quickly as possible.

Sincerely,

WILLIAM V. ROTH, Jr., *Chairman.*

U.S. DEPARTMENT OF LABOR,
SECRETARY OF LABOR,
Washington, D.C., August 26, 1981.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Governmental Affairs, Senate Permanent Subcommittee on Investigations, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Thank you for your letter of August 3, 1981 in which you ask for responses to questions arising from the Subcommittee's hearings on July 22 and 23, 1981, dealing with the Federal Employees' Compensation Program (FECA). I am pleased to provide you with the Department's responses, which I hope will be helpful to the Subcommittee.

Subsequent to the receipt of your August 3 letter, the Department received the transcript of statements made at the July 23 hearing by officials representing the Office of Workers' Compensation Programs (OWCP) and the Office of the Solicitor. The information provided here should amplify and, where appropriate, clarify the testimony given at the hearing. I note that the transcript does not include the prepared statement, and I request that it be included in the official record of the hearing.

There is no denying that the FECA program has been beset by problems, particularly since the 1974 legislative amendments. Major problems have centered around heavy use of the program by Federal employees, inadequate management systems and insufficient staff resources. The unfortunate results have included inefficient services to injured workers and incidents of mishandling of claims.

The Subcommittee heard from several witnesses as well as its own investigative staff of several such incidents.

We have been and are earnestly involved in efforts to rectify past errors and implement needed improvements as quickly as possible. I believe that substantial progress toward sound and efficient management and service has been made and I know that significantly more must be done in order to fully develop the high quality program we intend to have.

I have taken the liberty of including an addendum to the responses provided here, briefly describing some results of our efforts that are indicative of strong improvement trends in the administration of FECA.

I am convinced, however, that optimum progress in achieving program integrity and effectiveness requires statutory changes. The reforms included in the Administration's June 2 communication to the Congress would, among other things, help to eliminate the potential for misuse and abuse of FECA and increase the incentive and ability of workers to return to productive employment.

Please let me know if we can be of additional service in your review and related efforts in this area.

Sincerely,

RAYMOND J. DONOVAN,

Enclosures.

ADDENDUM

As noted in the prepared statement submitted to the Subcommittee, a major element in the Department's efforts to improve the administration of the FECA has been the increased scrutiny of the long-term disability payment rolls and the results that have come from that process. In FY 1980 nearly 56,000 [1] cases were reviewed, resulting in the removal of 2,246 claimants and the downward adjustment of benefits for 2,976 others. The estimated saving for FY 1980 alone is nearly $17 million. The impact of reducing benefits or removing a case also will be felt in future years, so savings go far beyond the fiscal year in which they are initiated. Through the first 9 months of FY 1981, over 41,000 cases have already been reviewed. By the end of FY 1981, we expect 2,600 cases to be removed from benefits and 2,200 cases to be adjusted downward. The estimated annual savings for FY 1981 from these reviews is $20 million. The projected long-term savings from these FY 1981 reviews alone will run from $360 to $576 million, based upon the average life expectancy of 16 years for each long-term disability case.

Comparable figures for FY 1978 and FY 1979, when the review of long-term cases began on a systematic basis, show the growing impact of these reviews as they result in slowing the growth in the overall number of long-term disability cases and increasing the savings in benefit payments. In FY 1978 there was an average of 46,178 long-term disability cases on the roll; 12,109 cases were reviewed during the year and 372 cases were removed, resulting in annual savings of $1,181,000. In 1979 there was an average of 47,318 cases on the roll; 34,649 cases were reviewed, 1,566 were removed and 1,275 were adjusted downward, resulting in an annual savings of $9,912,000. These results reflects both OWCP's willingness as well as its practical ability to improve control over its operations.

One of the major additional effects of this process, and the increased scrutiny on the initial adjudication of claims, has been the reduction in the growth of long-term disability cases. Had the growth trend for the period 1970–1976 continued into FY 1981, there would now be approximately 56,000 long-term disability cases. Instead, through the various quality control and improved management measures, OWCP has been able to reduce the upward trend in long-term disability claims by 7,800 fewer cases. This represents a "cost avoidance" of at least $92 million in FY 1980 alone below that which would otherwise have been expended.

Computerization of several aspects of the OWCP operation is another major element that has been introduced both to improve services and to assure control over the Program. In particular, computerized methods are now applied to medical bill payment processing. While there have been cases, as related to the Subcommittee, of mishandling and failures in control, the overall record demonstrates that the operation of the Program is under greater control than heretofore. For example, during FY 1981 to date (October 1980 to June 1981), of approximately

[1] At any given time approximately 47,000 cases are on the long-term disability roll. Additions, removals, and multiple reviews during the year of some cases on the roll results in a higher number of reviews than the number of cases on the roll at any one point in time.

605,000 medical bills processed, approximately 35,000 bills were rejected. Given the disclosure of mishandled cases in the New York Regional Office, however, further improvements are needed and measures are being taken to effect them.

QUESTION No. 1

1. *Exclusion and Debarment of Convicted Medical Service Providers.*—Please state whether the Department of Labor, under current law and regulations, has the authority to exclude or deny medical service providers from participation in the federal workers' compensation program based upon:

a. The indictment and/or conviction of the provider for a criminal offense related to services provided under FECA, a state or federal medical program, or some offense indicative of lack of professional integrity.

b. The administrative action taken against a medical provider in accordance with the procedures set forth in 42 USC 1320c–9(b) (Medicare/Medicaid) or 42 USC 1395y(d) (Secretary's refusal to pay).

c. The exclusion of a medical service provider from participation in a state workers compensation program.

d. The determination by the Secretary of Labor that a medical service provider:

1. has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment;

2. has submitted or caused to submit, bills or requests for payment for services rendered which the Secretary finds to be substantially in excess of such person's customary charges for such services, unless the Secretary finds there is good cause for such bills or requests which contain such charges; or

3. has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.

Please be advised that representatives of the Department of Labor testified that such a debarment/exclusion system had never been formally proposed at the Department of Labor. Furthermore, the Department of Labor witnesses speculated that such a system could not be developed under current regulatory authority and would require new legislation. Please contrast this opinion with the federal procurement debarment and suspension system, the authority for which exists entirely by regulation. (41 CFR 1–1.6)

RESPONSE

The Federal Employees' Compensation Act, as amended in 1974 by Public Law 93–416, granted injured Federal employees the right to "initially select a physician to provide medical services, appliances, and supplies, in accordance with such regulations and instructions as the Secretary considers necessary. . . ." Prior to this amendment injured employees were required to use available United States facilities such as the Public Health Service; employees could use private physicians designated by the Secretary only if the use of U.S. facilities was impracticable. See S. Rep. 93–1081, 93rd Cong. 2d Sess. (1974) p. 4–5. Because Congress recognized that workers desired a wider range of medical treatment and directed that such a choice be permitted under the Federal Employees' Compensation Act, the Department's regulations approved the use of all duly qualified physicians acting within the scope of their practice as defined by State law.

The responsibility of the Department under the FECA is to ensure that the treatment provided to injured Federal employees is designed "to cure, give relief, reduce the degree or period of disability, or aid in lessening the amount of the monthly compensation." See 5 USC 8103(a). Further, the Department is required to furnish the employee, either directly or indirectly, "necessary and reasonable transportation and expenses incident to the securing of" such treatment. If it is determined that the expenses incurred were necessary and reasonable, such expenses are to be paid from the Employees' Compensation Fund. Thus, under the FECA the Department of Labor's primary responsibility is to insure that proper medical treatment is provided to injured workers so that they will return to employment as soon as medically advisable.

In our opinion[1] the statute does not authorize the Department of Labor to

[1] Based on a preliminary decision of legal counsel. Counsel is in the process of conducting more intensive legal research on this issue. Upon completion, we will advise your office of the results.

prohibit any licensed medical providers selected by an employee from treating such employee or other employees or from receiving payment for the services provided out of the Employees' Compensation Fund. This is particularly true with respect to determinations of improper or unlawful conduct made by agencies other than the Department of Labor. With regard to determinations made by the Department such as are set forth in paragraph d. of Question 1, the statute provides authority for remedying questionable practices only as they occur in individual cases. Where specific billings for services under the FECA appear questionable, OWCP will delay reimbursement until they are satisfactorily resolved. Where such conduct possibly violates a Federal criminal statute, the matter is referred to the Office of Inspector General for investigation and where appropriate, referral to the Department of Justice.

Your letter references the Federal procurement debarment and suspension system set out at 41CFR 1–1.6. Those regulations were not issued by the Department of Labor but rather by the Administrator of General Services under the Federal Property and Administrative Service Act of 1949, as amended. Even assuming that Subpart 1–1.6 was authorized solely by regulation, the Government does have inherent power to establish the terms and conditions applicable to persons who wish to do business with it. Under the FECA, however, the Government is not engaged in procurement activity nor does it, with certain exceptions, contract for physicians' services.

QUESTION No. 2

2a. Identify all district offices that have and utilize fee schedules. Please currently utilized by such districts.

RESPONSE

Present procedures provide that if an OWCP office questions a specific fee as excessive and the physician takes issue with OWCP's finding, a State, Blue Cross or other fee schedule should be referred to as a guide to determine the reasonableness of the contested fee. These procedures do not require the use of fee schedules, and district offices are not utilizing fee schedules in the routine processing of bills. The test of payability is what is considered necessary and reasonable by OWCP (see copy of Chapter 5–200 of the FECA Procedure Manual, 9, a and b).

FEDERAL (FECA) PROCEDURE MANUAL (PART 5—BENEFIT PAYMENTS)

9. Fee Schedule

a. *The FECA Provides* for the payment of all expenses incident to the securing of necessary medical care which, in the opinion of the OWCP, are necessary and reasonable. There is no provision for the promulgation of a medical fee scehdule. It has not been practicable to establish a uniform medical fee schedule applicable to the entire United States because of the great geographic and economic differences. Therefore, since the act only requires that the medical expense be reasonable, it has been the OWCP's practice to approve physicians' fees without strict adherence to any specific fee schedule. *There has been some effort in the past to allow charges in substantial accord with the medical fee schedule of the Workmen's Compensation Board of the State (or nearby State) where the physicians practice. This approach has been used particularly in the cases of fees for operations which appeared to be excessive.* The BPC must, therefore, use discretion in determining reasonable fees as provided by the act.

b. *Where a Fee Schedule* is not applied, the physician is expected to charge fees not in excess of the prevailing rates in the same community for similar treatment to a private patient.

c. *In Auditing Claims for Reimbursement,* the amounts allowed for physicians' fees may not properly be limited to those amounts set forth in specific fee schedule. *Usually claims for reimbursement arise in cases where the treatment was rendered without prior authorization. In such cases the physician and claimant are usually unaware of or give no consideration to the possibility that the case comes under provisions of a workmen's compensation law. In the absence of such knowledge the fee would normally be established in accordance with the physician's fee schedule for worker's compensation.* Such reimbursement claims should be allowed for the full amount paid by the injured employee unless it can be established that the charge is unreasonable or exceeds the amount the physician regularly charges other patients for similar services. To allow an amount

less than that paid by the employee would in effect mean that the employee's rights under 5 USC 8103 of the act are not being being fully satisfied.

2b. Identify, by district, what dollar ceiling limits are currently being utilized in the approval of medical service provider bills, under present ADP bill payment procedures.

RESPONSE

FEC bill payment clerks may authorize payment, without supervisory authorization, up to specified amounts for a given provider type once the bill has been adjudicated as payable (see question 2c below). Bills for amounts in excess of these "ceiling" limits cannot be paid, once favorably adjudicated, without supervisory authorization.

The attached table identifies the ceiling amounts currently used in each FEC district office. In addition, we have attached a copy of an FECA Bulletin (No. 81–21, dated June 15, 1981) regarding these procedures and maintenance of these "ceiling" amounts, for your information.

Provider type	District office															
	1	2	3	6	7	9	10	11	12	13	14	15	16	17	25	50
Hospital	2,000	5,000	3,000	1,500	2,000	2,000	1,500	2,000	2,000	3,000	2,500	3,000	2,000	1,500	3,000	1,500
Nursing home	1,500	1,500	1,500	1,500	1,500	1,500	1,500	2,000	1,500	1,500	2,500	1,500	1,500	1,500	2,000	1,500
Nursing service	150	0	0	0	150	150	0	0	150	0	250	0	150	0	250	0
Pharmacy	100	50	20	20	100	100	20	150	100	150	250	150	100	20	100	20
Physician[1]	500	1,000	500	500	500	500	500	1,000	500	1,000	1,000	1,000	500	500	1,000	500
Physician[2]	500	500	500	500	500	500	500	500	500	500	1,000	500	500	500	500	500
Dentist	500	500	500	500	500	500	500	500	500	500	1,000	500	500	500	500	500
Chiropractor	500	200	500	500	500	500	500	500	500	500	1,000	500	500	500	500	500
Therapist	500	500	500	500	500	500	500	500	500	500	1,000	500	500	500	500	500
X-ray	80	50	100	50	80	80	50	200	80	150	250	150	80	50	200	50
Lab	75	20	100	20	75	75	20	150	75	150	250	150	50	20	150	20
Homemaker	100	0	0	0	100	100	0	0	100	0	250	0	100	0	0	0
Transportation[3]	100	100	100	50	100	100	50	150	100	50	250	50	100	50	100	50
Transportation[4]	50	50	100	50	50	100	50	250	50	50	250	50	100	50	50	50
Supplies	100	50	200	50	100	100	50	250	100	50	250	50	100	50	100	50

[1] MD and DO. [2] Not MD or DO. [3] GTR only. [4] Non-GTR; ambulance.

U.S. DEPARTMENT OF LABOR,
Washington, D.C.

FECA BULLETIN No. 81-21—JUNE 15, 1981

Subject: Use of "Authorizing Initials" and Provider Type authorized amounts in the FECS Bill Payments Subsystem (BPS).

Purpose and Scope: To remind appropriate District Office personnel of the proper procedures for use of FECS Bill Payment Subsystem (BPS) "authorizing initials," and obtain information regarding established authorized payment amounts by provider type.

The FECS Bill Payment Subsystem (BPS) utilizes a concept whereby bills that exceed a certain dollar amount, a parameter which varies according to provider type, must be specifically authorized for payment by a person with that (delegated) authority.

When a bill is submitted for an amount which exceeds that amount normally allowed for a submitting provider (by type), current FEC procedures require that an authorized bill pay examiner specifically indicate, with his/her initials and the date, approval of payment of the bill amount. *Only* in these circumstances (i.e., when the bill amount exceeds the parameters set for a specific provider type *and* when payment of the bill amount is properly authorized) should "authorizing initials" be entered in a bill payment transaction.

The amount-provider type parameters were initially established by the FEC National Office. Procedures have been established whereby, if district office experience of provider billings indicates that these parameters are set too low, the district office may request adjustment in the parameters provided that justification and recommendations for new amount parameters are submitted to, reviewed and approved by the Associate Director for FEC.

Maintenance of valid and current "authorizing initials" data is an important district office responsibility. District offices have responsibility to ensure that appropriate BPS procedures are used.

It has come to our attention that some district offices have circumvented the above described procedures in one (or both) of two ways: (1) instructing bill payment data entry staff to routinely enter authorizing initials whether or not these are required and/or provided; and (2) increasing amount-provider type parameters without DFEC National Office authorization.

Applicability: Appropriate OWCP National and District Office Personnel.

References: Memorandum of December 14, 1977, from Joseph M. Hunter to all Assistant Regional Administrators; Memorandum of June 6, 1978, from Reginald Johnson to all Regional Administrators, Assistant Regional Administrators, Assistant Deputy Commissioners and Systems Managers; Federal (FECA) Procedure Manual, Part 5, Benefit Payments, Chapters 5-1000 (3.e.(1)(b) and 3.f.(2)(ii)) and 5-1002 (2.c.(2)(d)).

Action: The following actions are required in each district office:

(1) The Assistant Deputy Commissioner, Systems Manager, and Fiscal Officer shall carefully review the referenced documents to ascertain conformity with established procedures and ensure that authorizing initials are being properly used by district office personnel.

(2) The Assistant Deputy Commissioner, Systems Manager, and Fiscal Officer shall review current amount-provider type parameters set in the Bill Payment Subsystem (BP Indset 411) to ensure that these parameters are appropriate for payment transactions which do not require specific authorization.

(3) The Assistant Deputy Commissioner will report, in writing, the amount-provider type parameters currently in use in the district office. A memorandum containing this information shall be sent to the Associate Director for FEC (Attention: Bill Cato. Coordination and Control Section) within 30 days of the effective date of this Bulletin.

Disposition: This Bulletin is to be retained until all actions required above have been completed, or the indicated expiration date.

JOHN D. MCLELLAN, Jr.,
Associate Director for
Federal Employees' Compensation.

2c. Identify the bill paying authority of bill paying clerks in each district office.

RESPONSE

The FEC bill payment clerical staff are responsible for making a number of determinations in the process of adjudicating bills for medical services including: (1) whether the medical service or treatment provided is appropriate for an accepted compensable medical condition; (2) whether the billed amount is reasonable for the service provided; and (3) whether the billed amount has not been otherwise paid.

This adjudication process is prescribed by procedure and is supported with a variety of reference materials and data processing capabilities. In the event that additional guidance is required in the adjudication process, bills are referred to supervisory, claims, or medical staff in the district office.

Once a bill for medical services has been favorably adjudicated, the bill payment clerks authorize direct payment provided that billed amounts do not exceed established ceiling amounts (see item 2.b., above) and the bill successfully passes a number of computer edits. Bills which do exceed the established ceiling amounts must be authorized by supervisory personnel while those failing computer edits must be researched and, if appropriate, reprocessed by bill payment staff (generally) other than those making initial authorization.

Compliance with established procedures and the integrity of the bill payment authorization process is the responsibility of the Assistant Deputy Commissioner in each FEC district office.

QUESTION No. 3

BOSTON PILOT PROJECT

Testimony was presented indicating that OWCP has had great success in conducting workers' compensation verification investigations using Wage and Hour Division investigators and that the Boston Project is being expanded. Subcommittee investigation indicates that such expansion may be minimal, such as the commitment of only one man-year per region. Please identify the full extent of the planned expansion of the Boston Project on a regional basis.

RESPONSE

The use of Wage-Hour Compliance Officers to investigate claims under the FECA has been expanded from the Boston Project to encompass the entire country. The Wage-Hour Division has pledged at least one compliance office work-year (1,500 actual investigative hours) for each ESA region. The level of resources that the Division can commit to this effort is severely limited by the overriding enforcement responsibilities and obligations prescribed by the several statutes pertaining to fair labor standards, minimum wages and hours of work.

Cases for investigation will be chosen from those on the periodic compensation roll. The criteria for selecting a case would include (but not be limited to) such circumstances as:

a. A refusal on the part of claimant to provide detailed medical reports outlining the status of his or her condition;

b. Failure on the part of a claimant to provide information on his or her earnings;

c. A claimant who has been receiving compensation for a long period of time in relation to the injury for which the claim was accepted; or

d. Receipt of a tip, anonymous or otherwise, giving indication that a claimant may not be disabled.

It is anticipated that each ESA region should complete approximately 90 investigations per year. This figure is based on the experience of the Boston project, in which the investigations each took an average of 16 compliance officer hours.

The instructions for this investigative procedure have been drafted and their release to the various district offices should take place within the next two weeks. The target date for national implementation of the procedure is October 1, 1981.

QUESTION No. 4

MEDICAL PROGRAM EFFECTIVENESS

Testimony was presented which stressed OWCP's commitment to utilize medical resources in the evaluation of claims and in examining and approving medical bills. The role of the Division of Medical Standards and Services was stressed in providing guidelines to district offices.

a. Please identify, as of July 23, 1981:

1. How many District Medical Director positions are authorized for OWCP and which districts actually have a full-time Medical Director.

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(Identify which of these districts have a director who works full-time during normal duty hours.)

2. Which districts have a part-time Medical Director.

3. Which districts have no part- or full-time Medical Director.

Response

As of July 23, 1981, 16 District Medical Director positions were authorized by OWCP. Medical staffing was as follows:

	Full-time physician	Part-time physician	No physicians
District office:			
1—Boston	1		
2—New York		1	
3—Philadelphia	1		
6—Jacksonville	1	1	
7—New Orleans			X
9—Cleveland	1	2	
10—Chicago			X
11—Kansas City		1	
12—Denver	2		
13—San Francisco	1		
14—Seattle			X
15—Honolulu	1		
16—Dallas			X
17—Atlanta	1	1	
25—Washington, D.C	1		
50—Special Claims			

Note that all offices use consultant and/or contract physicians on an as needed basis.

b. Please identify as of July 23, 1981:

1. How many medical positions are authorized for the Division of Medical Standards and Services, and how many of these positions are filled.

2. Please provide copies of all medical guidelines developed by the Division of Medical Standards and Services.

Response

As of July 23, 1981, two medical positions were authorized for the Division of Medical Standards and Services, none were filled. On June 19 and July 17, 1981, respectively, the two former incumbents of the positions resigned to pursue other careers. Recruitment of their replacements has been initiated.

Copies of medical guidelines are attached.

STATUS OF GUIDELINES

1. Hearing loss

September, 1980—incorporated in Federal (FECA) Procedure Manual.

2. Laboratory tests

September, 1980—issued as FECA Program Memorandum.

3. Low back

a. June, 1980—cleared by DFEC for pilot use.

b. July, 1980—DO No. 25 pilot began.

c. October, 1980—general distribution for informational purposes.

d. June, 1981—DO No. 13 pilot began; distributed to DMD's for information and comment; incorporated in draft medical manual (submitted to DFEC).

4. Asbestosis

a. March, 1981—current version submitted to DFEC for distribution (earlier versions were rewritten based on DFEC comment).

b. June, 1981—distributed to DMD's for information and comment; incorporated in draft medical manual (submitted to DFEC).

c. August, 1981—incorporated in Federal (FECA) Procedure Manual.

5. Stress

a. May, 1981—submitted to DFEC for distribution.

b. June, 1981—distributed to DMD's for information and comment; incorporated in draft medical manual (submitted to DFEC).

c. August, 1981—submitted to consultant physician for evaluation and comment.

15. *Sacroiliac Disease (Low Back Strain).* (Continued)

(3) *The official Superior Should Also Be Required to Submit:*

(a) A copy of the employee's application for employment;

(b) A copy of the pre-employment medical examination;

(c) Copies of all other medical reports available at the employing establishment;

(d) A transcript of the employee's sick leave record, including the reason, if known, for each period of sick leave; and

(e) Any other information which the employing establishment possesses about the employee's health during or prior to the Federal service.

16. *Hearing Loss Due to Acoustic Trauma.* Instructions in this paragraph are not concerned with hearing loss due to a single trauma. These instructions relate to those cases where it is alleged that hearing loss was caused by excessive or harmful noise in the day-to-day work environment. In the adjudication of these cases, the following facts should prove helpful to the CE.

a. *Characteristics.* There are three classes of hearing loss. They are:

(1) *Conductive Loss.* This loss is caused by a defect in the external or middle ear from disease or injury. It is never caused by excessive noise in the work environment.

(2) *Perceptive Loss.* This loss arises in the inner ear. It may be caused by excessive noise in the work environment. It may also be caused by other factors, such as diseases of the brain, general or infectious diseases, drugs, or advancing age. For this reason, the claims examiner's development of the evidence must include a showing whether some factors other than work may be a probable cause of the hearing loss.

(3) *Mixed Type Loss.* Dut to both kinds of loss—the conductive loss and the perceptive loss.

(4) *Damage to Hearing* by sound or noise is influenced by these factors:

(a) *Intensity of Sound.* This is measured in decibels. Noises with an intensity in excess of 85 decibels can prove damaging to the hearing. The intensity is determined by a noise-level meter. To the fullest extent possible, the results of a sound level survey of the work area should be required before a claim is adjudicated.

(b) *Frequency or spectrum of the noise.* Lower pitched sounds are less damaging. Those involving tones above 1,000 cycles are the more harmful.

(c) *Continuity of the sound.* Continuous noise is more harmful than intermittent sounds.

(d) *Duration of the exposure.* Prolonged exposure has a cumulative effect on hearing loss.

(e) *Individual susceptibility.* All persons are not equally susceptible to harmful noise.

(5) The claims examiner should not attempt to resolve any question of causal relation or degree of permanent disability until the employee has been examined by an otologist and the case contains an appropriate report from the medical specialist.

b. *Evidence.* In these cases the CE should obtain the following evidence:

(1) *From the Employee*: (Use Ltr. CA–1082)

(a) The specific reasons why the employee believes the hearing loss is due to work; a statement giving the date hearing loss was first noticed, the date loss first related to employment and the reason why, and the date of last exposure to noise considered hazardous;

(b) A detailed description in chronological order, of the particular work factors which the employee believes to be the cause of the hearing loss; the employee should also state whether any protective devices were used, such as ear defenders, describe the devices and state the approximate number of hours per day and days per week used;

(c) Whether the employee has had any previous ear or hearing problems and, if so, the full details of these problems including when and the names and addresses of all physicians who examined or treated the employee;

(d) Full details if a claim for workers' compensation benefits from any source was ever filed on account of this or any condition affecting the ears or hearing, including the date of the claim, the name and address of the office where the claim was filed, and a description of any benefits received; and

(e) Originals or copies of all audiograms made by any physician or medical facility at the claimant's request without authorization from the official superior or OWCP.

(2) *From the Official Superior:*

(a) The employee's complete work assignment record at the Federal installation showing the positions held and inclusive dates of assignments, and describing the duties performed, the type of noise to which exposed, and the length of time of such exposure on each assignment;

(b) A complete description of the employee's work sites, including a diagram showing the dimensions and layouts of the buildings, and a discussion of the noise hazards at the time the employee was on duty;

(c) A description of any sound level tests or surveys made of the employee's work areas and a complete report of the findings (if no tests or surveys have been made, the official superior should be asked to have them made if possible);

(d) The safety precautions (such as ear defenders, noise suppressors, acoustical engineering, etc.) taken to eliminate or reduce noise hazards;

(e) Whether any other employees performing the same work under the same working conditions had similar complaints;

(f) A copy of the report of the employee's preemployment medical examination;

(g) Medical records that show any ear trouble and copies of all available audiometric tests;

(h) The date and time the employee was last exposed to noise on the job; and

(i) A statement showing whether the employee was removed from a noisy environment at least 16 hours before hearing was tested.

c. *Loss of Hearing Determinations.*

(1) *References.*

(a) *Occupational Exposure to Noise* published 1972 by the U.S. Department of Health, Education and Welfare, Health Services and Mental Health Administration, National Institute for Occupational Safety and Health.

(b) *Guides to the Evaluation of Permanent Impairment* published in 1971 by the American Medical Association (AMA).

(c) FECA Program Memorandums No. 8, 29, 69, 105, 139, 154, 162, 179, 181, and 217.

(d) FECA PM 3–600, Disability Evaluations.

(2) *Policy.* Hearing loss determinations are made in accordance with standards of the National Institute for Occupational Safety and Health (NIOSH) using the frequencies of 1.000, 2.000, and 3 000 cycles per second (cps). These standards are found in Chapter VI of *Occupational Exposure to Noise.* Using these standards, if the hearing loss does not exceed 15 decibels when the audiogram is based on an ASA calibration, there is no compensable hearing loss under the FECA.

Because NIOSH studies do not include a method for calculating the percentage of binaural hearing loss, this calculation will be made by using the established mathematical method in the AMA Guide after the percentage loss of hearing in each ear has been determined in the frequencies of 1,000, 2,000, and 3,000 cps.

(3) *Referral of Hearing Loss Cases.*—After obtaining all of the pertinent, available medical and factual evidence, the claims examiner will prepare a statement of accepted facts and refer the employee for otological evaluation and advisory medical opinion on the relationship of any hearing loss to the employment. The examining physician should be asked to include in the report an opinion as to what portion of the hearing loss was caused by presbycusis. The physician should also be instructed to make use of retesting and additional tests and techniques which are considered appropriate, in those cases where it is found the initial tests were inadequate, or there is reason to believe the employee is malingering.

In no case will examination by a physician or medical facility be authorized unless the physician or facility can certify that no more than one year will have passed from the date the audiometer to be used was last properly calibrated, until the date of the scheduled examination. Each physician or facility should be asked to include in the report of examination, the date of calibration of each instrument used and by whom the calibration was performed.

All claims of hearing loss will be referred to the district medical advisor for evaluation of the extent of impairment before an award is made. If there is no reasoned medical opinion regarding the cause of the hearing loss, the medical advisor will be asked to file an opinion on the relationship of the hearing loss to the employment. The claims examiner will certify the correctness of the medical advisor's computations on Form CA–51, Hearing Loss Medical Opinion.

Immediately after the report of examination is received and evaluated, the employee or representative must be informed. The employee must be told the nature and extent to hearing loss found, the percentage of loss, the date the schedule award will begin, and the date that is considered the date of injury (i.e., the date of examination or last exposure). The following is suggested wording for the notice:

The report of the otological examination on (date) by (physician's name) has been received. It shows that you have a (percentage) hearing loss as a result of (noise exposure, presbycusis, or a combination of both). (All or percentage) of the loss has been found to be a result of your Federal employment, and you will be awarded compensation for it. The evaluation of your case took into account all noise exposure you had up to the date of the examination. The award will begin on (date), (date of examination or last exposure), which will be considered the date of your injury. You will receive an award notification when it is processed.

(4) *Awards Made Under Former Procedure.*—If an employee or representative asks for review of a schedule award made under the former modified AMA standards of 1,000, 2,000, and 4,000 cps., a new determination will be made by the Branch of Hearings and Review in accordance with the present policy. Before a final decision is made, the file will be referred to the OWCP Medical Director who will arrange to have the employee examined by an otologist using the NIOSH standards (refer to FECA PM 3–600.1d(2). Awards made under the former standards will not be reviewed unless review is specifically requested by the employee or a representative.

(5) All claims adjudicated by OWCP district offices on and after March 7, 1977, will be subject to the revised averaging formula. Any decisions on claims currently under reconsideration, hearing, or appeal, will be based on the averaging formula in use at the time that the claim was initially decided.

(6) In cases of hearing loss where a schedule award is paid before noise exposure terminates, no additional award will be paid for periods of less than one year from the beginning date of the last award or the date of last exposure, whichever comes first. If, in such a case, the employee requests review of the case, the employee must be asked to clarify whether the request is for review of the award or for additional compensation as a result of additional noise exposure. If the request is for review of the prior award, the case will be processed as a request for reconsideration, hearing, or appeal, whichever is applicable. If the request is for additional compensation for loss due to exposure subsequent to the effective date of the prior award, the examiner will inform the claimant that a new claim should be filed one year after the beginning date of the last award or the date of last exposure, whichever occurs first. (See ECAB Docket No. 77–27).

(7) Where the evidence clearly establishes that an award for hearing loss was faulty, the claimant should be directed to undergo retesting. If the claimant refuses retesting or is uncooperative during retesting, the award should be vacated and overpayment action should be initiated. This can only be done where the evidence clearly shows that the hearing test upon which the award was based is faulty. The Findings of Fact in the Compensation Order Vacating Schedule Award must explain the basis for the adverse decision.

17. *Radiation and Similar High Energy Injuries.* The claims examiners and their supervisors in the district offices should not attempt to process or adjudicate cases involving radiation and similar high energy injuries. These cases include, but are not limited to, injuries involving roentgen rays (X-rays); radiosotopes and radionuclides; radar; microwaves; radio frequencies; alpha and beta particles; gamma rays; high energy neutrons; and laser beams. (These do not include common electrical burns and shocks.) When received in the district offices, such cases should be forwarded immediately to the National Office for supervision, development, and adjudication.

18. *Asbestosis.*

a. *General Discussion.* Asbestos is a naturally-occurring mineral fiber which has multiple industrial uses due mostly to its binding and heat-retardant properties. Since the early years of the Second World War, industrial use (and production) of asbestos fiber products has increased dramatically in the United States. It has been estimated that as many as eleven million living Americans have experienced some occupational exposure to the various asbestos mineral fibers, with considerable numbers of those exposures in the Federal industrial work force.

Exposure to asbestos fibers has been epidemiologically linked to a number of human diseases. Asbestosis, diffuse interstitial fibrosis of the lungs' parenchymal

tissues, is the most commonly recognized disease related to such exposure. Recent evidence has suggested, however, that asbestosis may be one of the least frequently occurring asbestos-related diseases. Asbestos exposure has also been shown to be a causal factor in a variety of pulmonary (pleural and parenchymal) and gastrointestinal disorders. Probably least recognized is the recently established relationship of this mineral fiber to carcinogenesis including the development of mesothelioma and bronchogenic carcinoma.

Mesothelioma, for instance, once an extremely rare human cancer, has been observed in significantly increased incidence in recent years. It is estimated that 85–90 percent of all diagnosed mesotheliomas are due directly to asbestos exposure. Some evidence also exists linking asbestos exposure to gastrointestinal carcinoma, but this relationship is less well-documented.

As is the case with most environmentally-related cancerns, the carcinomas which occur as a result of asbestos exposure are not pathologically distinctive (with, of course, the exception of mesothelioma). Pleural abnormalities (plaques, thickening, calcification) and asbestos-related fibrosis are more pathologically distinguishable but may also develop from other causal factors. In these circumstances, any diagnosis of asbestos-related disease must be explicitly based on a careful and complete evaluation of an individual's occupational exposure history.

In addition to the essential importance attached to a complete occupational history in supporting a diagnosis of asbestos-related disease, there are two other factors which must be considered:

(1) *Dose-Response Relationship.* It is established that the longer and/or more intense the exposure to asbestos, epidemiologically the more likely that an asbestos-related disease or abnormality will become manifest. Generally, this consideration must be applied, with an awareness of the possible individual hypersensivity of the exposed person (individual variability).

(2) *Latency Period.* In the case of most asbestos-related diseases, abnormality or disease usually does not occur for several years (20+) after onset of exposure. Excess deaths related to asbestos exposure and resultant diseases are relatively unusual until twenty years after onset of exposure, yet become increasingly frequent beyond that latency period.

There are, of course, many other factors which must be evaluated in establishing a diagnosis of asbestos-related disease. Once such a diagnosis has been made, however, additional factors must be considered in evaluating the functional effect of the diagnosed condition on the individual:

(1) An individual exposed to asbestos may demonstrate anatomical or structural *abnormalities* without suffering any impairment of the function of the organs affected or any related symptoms which may cause disability.

(2) *Impairment*, which is a purely medical condition, is the anatomical or functional loss or reduction of body or organ function in reference to the activities of normal life, excluding work.

(3) *Disability* within the context of the FECA is the loss of earning capacity which results from (among other factors) a lack of ability for a certain level of a specific type of occupationally required performance.

(4) Pleural plaques (on chest X-ray) constitute a typical example of anatomical abnormalities which may not cause any impairment or disbility.

(5) Ferruginous bodies ("asbestos bodies") in the sputum are also usually only indicative of exposure without demonstrating the presence of active disease.

While abnormalities may be present without consequent impairment or disability, so too may an individual demonstrate impairment without disability. Each individual demonstrates normal variations impairment without disability. day to day or from environment to environment. Although we have already provided a concept of "impairment", this variability in the normal pulmonary function disallows application of this concept to any reduction in organ function at least as far as pulmonary function is concerned. Therfeore, for compensation purposes, pulmonary impairment exists when the actual level of pulmonary function is reduced below an arbitrary level which is considered as the lower limit of "normal". The AMA has established this level at 85 percent of standard normal tables for certain measures of pulmonary function.

Even if an individual were to demonstrate a pulmonary impairment (in this context), he/she may not be "disabled" if the level of performance required by his/her normal employment is not adversely affected. (On the other hand, an individual without significant impairment may be totally "disabled" as a result of related symptomatology.)

It should be clear from this extremely limited discussion that the development and adjudication of asbestos-related disease claims filed under the FECA

will be relatively complicated. The following procedures, built upon existing applicable procedures, take the peculiar factors of asbestos-related disease into consideration and are structured to simplify the entire process to the greatest extent possible.

In summary, for purposes of medical consultant orientation, a diagnosis of asbestos-related disease would be consistent with the following guidelines:

(1) A history of exposure of any duration to asbestos dust;

(2) A latency period of a minimum of 10 years (although typical asbestos-related disease presents 20–40 years after onset of exposure);

(3) Pleural plaques or pleural thickening with documented exposure; or
Interstitial fibrosis with epidemiological support in occupational history, or
Neoplasia with epidemiological support in occupational history, and
Non-industrial exposure ruled out as sole causative factor, and
Non-occupational pulmonary conditions are not implicated as sole causative factors.

b. *Time Limitations.* In order to evaluate the timeliness of a claim for disability due to latent occupational disease, three dates must be considered:

(1) Date of injury (date of last injurious exposure);

(2) Date of awareness of impairment or illness;

(3) Date of awareness of the relationship between an illness and the conditions of Federal employment.

The date of last injurious exposure to asbestos is the date of (last) injury and, therefore, establishes the applicable time provisions of the FECA.

The time limitations in effect on the date of last injurious exposure are those which must be applied in evaluating the timeliness of filing an FECA claim.

c. *Civilian Federal Employment.* Normal procedures for verification of civilian Federal employment will apply in asbestos cases. Individuals who wish to make claim on account of employment at currently disestablished Federal facilities should be provided with necessary forms and instructed to file with the OWCP office which has jurisdiction over the state in which last Federal occupational exposure occurred or with the employing agency's national headquarters.

It is expected that many claims will be filed by individuals who were employed by currently disestablished facilities, or with very brief periods of Federal employment (often many years in the past). Procedures should be established to obtain Official Personnel Folders, including medical records, from the Federal Records Centers. In some cases, it may be desirable to coordinate this effort with the activity of the employing agency which will also require these records to provide necessary information.

The Navy's Civilian Personnel Office headquarters has advised that most employees of private shipyards during World War II were not regarded as Federal employees even though the production activities of these facilities were under direct or indirect control of the U.S. Government. A decision on individual cases must be made, however, on best available evidence pending further clarification of these relationships.

Attention must be given to the potential dual benefits situations that may arise in many cases due to the high frequency of employment turnover. Many FEC claimants will base their cases on brief periods of Federal employment combined with other periods of employment, with exposure, in the military and private sectors.

d. *Fact of Injury.* Current levels of safe exposure to asbestos dust (based on current OSHA standards and subject to change should either the OSHA standards change or the proposed NIOSH standards be adopted) are:

(1) 2 fiber/cc time weighted average (TWA), or

(2) 10 fiber/cc ceiling.

If, as generally expected, actual measurements of dust levels are unavailable, the normal presence of asbestos dust on work surfaces (although not necessarily visible in the workplace air) will be considered indicative of injurious exposure.

As in all occupational disease cases, it is necessary to obtain available information from both the employee and the employing agency regarding the claimant's current medical condition and the medical history relevant to the claimed condition. Special emphasis should be given to obtaining any lab test results and chest X-ray records from previous examinations or health screening programs (such as in naval shipyards). Reports on any examinations, treatment, or period of hospitalization for any previous similar condition or pulmonary problem must be obtained.

(While the medical evidence required to establish fact of injury for the purposes of initiating OWCP medical referral (see below) is minimally defined, this

should not influence the Office's efforts to obtain complete available medical evidence for purposes of substantiation and evaluation.)

In death cases, a certified copy of the death certificate and any existing autopsy reports should be obtained in addition to the above medical reports (as available).

e. *Performance of Duty (Exposure).* It is necessary to obtain a complete, chronological occupational history from the employee (current SF–171), which identifies the duration and duties of each Federal and private employment job held and further specifies those jobs which involved exposure to dust (of any kind), chemicals or other possibly toxic substances, and the sources of such exposure.

For each job which involved such exposure (including non-Federal employment), the claimant shall specifically describe the inclusive dates of employment, the number of hours worked per week, sources of dust, chemicals, etc., and the extent, duration and degree of exposure. The claimant shall also identify and describe any non-occupational exposures to any of the above substances, including frequency, extent, duration and degree.

The employee should describe any safety instruction or devices that were provided by the employer. Specific information regarding the use of respirators, protective clothing, and ventilation equipment should be obtained. The date on which these devices were first used should be identified.

The necessary exposure information and employment history may be obtained by having the claimant complete sections one through six (section seven should be completed by the treating physician) of the sample "Medical History and Examination for Asbestos Related Diseases" form (See Exhibit 1).

In death cases, the claimant should also be requested to provide a complete occupational history for the deceased employee, description of each job held with any known details or evidence of exposure, and, if appropriate, the names and addresses of surviving co-workers in similarly exposed jobs.

In both of the above cases, the employing agency is required to provide details of the claimant's employment, including identification and description of each job held and inclusive dates of employment. The agency should provide details regarding any exposure which occurred in each job with identification of the types of dust (chemicals or pollutants) to which exposed, and available data concerning the concentrations of dust and the extent, duration, and frequency of exposure during the average work day. If the claimant is still employed (or was so employed within the last three months), the employing agency should (if necessary conduct and) provide results of air sampling of the ambient air and the air in each location where the employee works (worked) taken while work is in process in each location. The air sample results should be reported in units of fiber/cc-time weighted average. If the employee has stopped working more than three months prior to the date of the claim, the employing agency should provide estimates of the limits of exposure during the periods of employment. The employing Agency should also provide a description of safety regulations, education, and precautions applied in the jobs in question, identify the initial dates for application of these safety procedures, describe applicable enforcement procedures, and comment on the claimant's compliance with safety regulations.

If descriptions of the nature and extent of exposure, from either the employer or the employee, are not based on actual air sample results, a description of the exposure using the following categories and terms should be requested. For this purpose, the "Asbestos Exposure Summary" form should be used (see Exhibit 2):

(1) *Nature of Exposure.*

(a) *Primary.* The individual's normal duties required actual manipulation of asbestos and/or asbestos products and generated dust;

(b) *Secondary.* The individual's normal duties regularly involved work alongside of other individuals primarily exposed or placed the individual in the same confined spaced on a regular basis;

(c) *Intermittent.* The individual's normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated; and

(d) *Environmental.* The individual's normal duties were performed at a location or facility (such as a shipyard) where asbestos was used but the individual had no normal exposure in excess of ambient levels.

(2) *Degree of Exposure.*

(a) *Heavy.* Asbestos dust was usually visible in the air;

(b) *Moderate.* Asbestos dust was generally visible on work surfaces but did not cloud the air;

(c) *Light.* Asbestos was used in work area but was generally not visible (although detectable). The "light" concentration of asbestos dust conforms to air sample results less than the 2 fiber/cc twa safety standard; and,

(d) *Ambient.* Asbestos levels did not exceed normal levels in the air outside of work spaces.

(3) *Frequency of Exposure:* Hours per day.

DFEC shall transmit factual information submitted by claimants in response to DFEC requests to the employing Agency for comment.

An employing agency's reasonable contradiction or controversion of an alleged exposure level, when not supported by air sample results, should be resolved by sworn witness statements obtained from the employee's co-workers.

As indicated above, based on current OSHA standards, exposure of less than 2 fiber/cc twa (light) is not considered potentially injurious. Because of individual hypersensitivity, however, clinical evidence may establish a definitive diagnosis based on an occupational history with limited exposure. Exposure in excess of 2 fiber/cc for any period may be potentially injurious. It is epidemiologically established, however, that the longer the duration and/or higher the intensity of exposure the more likely that asbestos-related abnormality or disease will occur.

In each timely filed case where occupational exposure in excess of 2 fiber/cc (moderate or heavy) during the course of Federal employment is established (and not contested by the employing agency) and where evidence is presented which indicates possible existence of some asbestos-related abnormality, a complete Statement of Accepted Facts will be prepared and the claimant will be referred, at OWCP expense, to an OWCP-authorized specialist for complete and current evaluation in accordance with the OWCP Medical Examination Requirements in Asbestos Disease Cases (see Exhibit 3).

In those cases where these conditions are not satisfied, the claimant shall be instructed to arrange for submission of a current medical report from his treating physician which meets all of the requirements of the OWCP Medical Examinations Requirements for Asbestos Disease Cases. If the submitted report satisfies OWCP requirements and the case is accepted, the cost of the examination is reimbursable.

f. *Medical Evaluation.* The medical evidence submitted to establish the possible existence of asbestos-related abnormality will, at a minimum, include:

(1) An X-ray report indicating pleural or parenchymal abnormality; or,

(2) Report of clinical examination indicating pulmonary fibrosis.

If the claimant submits a report of recent medical evaluation from a personal physician at the time of filing (or prior to our referral), the report should be carefully evaluated to determine its completeness according to the requirements of OWCP's medical guidelines. If the report indicates asbestos-related disease but is deficient according to OWCP requirements, the claimant should be referred, as described above, at OWCP expense.

In death cases, when available medical evidence has been received, it should be evaluated for completeness and relevancy and referred for medical evaluation (with a narrative Statement of Accepted Facts) to the OWCP consultant specialist as described below.

(1) *Referral to Pulmonary Specialist.* Each OWCP District Office affected should develop a list of board-certified pulmonary specialists in its Region who express a willingness to perform the required examinations and provide complete reports (with reference to OWCP medical requirements, forms and procedures) on FECA claimants. The reports received from these individuals should be monitored for completeness and reliability to justify continued referrals.

A copy of each referral letter will be maintained by the Medical Director in a special file. Each time a referral report is received which requires supplemental information, a copy of the supplemental request will be attached to the original letter. The Medical Director will have responsibiilty for monitoring performance of the referral specialist and will take appropriate action to suspend referrals to physicians whose reports are consistently incomplete, unreliable, or consistently delayed.

As indicated above, when the "time" and "exposure" issues are favorably resolved and some asbestos-related problem is indicated, the claimant should be referred to a pulmonary specialist. A narrative Statement of Accepted Facts, a job description, copies of medical evidence and Form CA–1333 should accompany the letter to the pulmonary specialist. Forms SF–1012 and 1012A should be enclosed with the letter sent to the claimant.

As indicated above, specific guidelines have been developed for use in evaluation of asbestos-related disease cases. These guidelines describe the tests that should be conducted and the required content and format of the medical reports submitted by referral physicians. The reports should be carefully evaluated for compliance with these requirements. Bills for these evaluations should be paid promptly upon receipt.

(2) *Medical Work-Up.* The medical evaluation guidelines (summarized in Exhibit 3) which have been adopted require that the referral physician conduct an evaluation which includes the indicated tests and provide a report which includes the following information and test results:

(a) *Occupational history* which includes reference to the claimant's job history, length, extent, and duration of exposure to asbestos, other dusts or toxic chemicals, during Federal and non-Federal employment, and as a result of any non-occupational exposure.

(b) *Medical history* which includes reference to past illnesses or injuries, family medical history, previous pulmonary problems, history of related symptoms (dyspnea, endurance changes, sputum production, etc.), symptoms occurring while exposed or during work, and complete smoking history (in pack-years).

(c) *A physical examination* which describes the following items:

(i) Claimant's general appearance and performance;

(ii) Claimant's sex, age, height and weight;

(iii) The presence or absence of cyanosis, clubbing, nicotine stains, edema, and hepatomegaly;

(iv) The pattern of claimant's breathing (presence and degree of dyspnea, etc.);

(v) The results of cardiac examination; and

(vi) The results of chest examination including configuration, findings on percussion and ausculation, and the presence or absence of basilar rales.

(d) If the claimant presents histologic confirmation of mesothelioma, in the presence of adequate exposure and timely filing, the case has sufficient medical evidence for referral to the DMD without further development. If the claimant presents histologic confirmation of carcinoma of the lung, pulmonary testing is not indicated or necessary prior to referral to the DMD.

(e) *X-rays and Laboratory Tests.*

(i) *PA, Lateral and R & L Oblique X-Rays.* A full size X-ray shall be taken under the supervision of a board-certified radiologist and read by either a board-certified radiologist or pulmonary specialist.

This radiologist's reading must include a description of the quality of the film and all radiographic findings. The examining physician will also review the film for these same purposes. The film should be retained for possible review by this office on a loan basis.

The X-ray interpretation must include a description of any abnormality or pathology present with special attention given to the presence of pulmonary hypertension, fibrosis, carcinoma, or mesothelioma. If any abnormality or pathology is present, the description must include the following information:

A. Presence or absence of opacities described by type, size, shape, distribution and profusion;

B. The presence or absence of pleural thickening, plaques or calcification with description of site and extent;

C. The presence or absence of ill-defined diaphragmatic or cardiac outlines with description of extent; and

D. Any other findings of past or present problems.

Additional X-ray views may be obtained if indicated by the radiologist. Lung tomography and/or CAT scans may be performed if recommended by the radiologist and approved by DMD if such tests will make a difference in adjudication of the claim.

(ii) *Pulmonary Function Studies.* Pulmonary function studies must include measurement of the following fusctions (the report of the results of the FVC, FEV_1, and Diffusing Capacity must include actual recorded values, the percent of predicted normal, and identification of the normal standard applied for tests conducted before and/or after the use of bronchodilators). These studies should be performed under the supervision or direction of a board-certified pulmonary specialist.

A. *Forced Vital Capacity* (FVC) and *Forced Expiratory Volume in One Second* (FEV_1) measured in liters and representing the best of three efforts; and the

FEV1/FVC Ratio ($FEV_1\%$) computed from these results. The report of the results of this test must include:

aa. Date and time of the test;

bb. Name, file number, sex, age, weight and height of the patient;

cc. Name of the physician supervising the test, if different than the referring physician;

dd. A description of the patient's ability to understand and follow instructions and the degree of cooperation in performing the test;

ee. Whether and why a bronchodilator was used and its impact on test results;

ff. The paper speed and the name of the instrument used;

gg. The date of last calibration of the instrument.

The report must be accompanied by appropriately labeled spirometric tracings (for all tests) showing distance per second on the abscissa and distance per liter on the ordinate.

B. *Carbon Monoxide Diffusing Capacity* (Single Breath Method). The results must be reported in mm/ml/mmHg. The report of the test must include estimated alveolar volume (based on measured FRC), corrected for pressure.

C. *Arterial Blood Gas Study* (administered at rest). A blood gas study may be done during exercise only if not medically contraindicated and if, in the opinion of the examining physician, it is necessary for diagnostic purposes. Report of the ABG study must include recorded values for pCO_2, pO_2 and pH collected simultaneously and the date and time of the test.

(iii) *Electrocardiogram* results submitted with tracings.

(iv) *Complete blood count.*

(f) *Medical Impression and Opinion* which includes:

(i) Diagnosis of all pulmonary pathologies;

(ii) Diagnosis of any other disease conditions present;

(iii) Recommendations regarding the indicated course of treatment to improve the level of pulmonary function;

(iv) A discussion of the findings as regards the indicated degree of pulmonary impairment and exertional limitations (with reference to the enclosed job description); and

(v) Discussion of work-relatedness, including a detailed discussion of other etiological factors for each of the diagnosed conditions.

(3) *Referral to OWCP Consultant.* Upon receipt of reports from the OWCP referral physicians, the claims examiner should carefully review the report for completeness and compliance with the requirements of OWCP's medical guidelines. When satisfied that the report is adequate, authorization for payment of referral physician's bill should be made. If the report is incomplete or does not conform to the listed requirements, a supplemental report will be obtained from the examining physician.

When complete available medical evidence has been obtained in a death case, the following procedures for final medical review also apply.

The evidence of record should be determined by the claims examiner to be complete so that a final medical evaluation of the entire case file will allow a decision on the claim. The contents of the entire case file will be referred to an OWCP Medical Consultant—another board-certified pulmonary specialist acting as pulmonary DMD for consideration of the following issues:

(a) Diagnosis: Are the laboratory and physical findings adequately supportive?

(b) Work-relatedness: Has Federal occupational exposure contributed to development of diagnosed conditions by direct cause, aggravation, acceleration or precipitation?

(c) Impairment: With reference to the *AMA Guides*, what percent pulmonary impairment is indicated?

(d) Disability: Is the evidence sufficient to allow a determination of the extent and degree of disability for normal work (current or last) as a result of the diagnosed condition?

(e) Prognosis: Is the disability partial or total, temporary or permanent?

(f) Treatment: Is the recommended treatment appropriate?

(g) Follow-Up: When should the next pulmonary evaluation be performed?

(h) Employment: On the basis of current medical findings, medical knowledge, documented working conditions (if still employed), should the claimant continue present employment (if still exposed)?

g. *Approval/Denial.* The case should be accepted (or rejected) on the basis of the medical evidence of record and the consultant specialist's opinion. Acceptance

of the case allows immediate payment of medical bills and implementation of a medical treatment plan approved by the OWCP consultant and/or the DMD.

When a case has been accepted for some asbestos-related disease, consideration must then be given to additional factors which bear on entitlement to monetary compensation.

(1) *Impairment Evaluation* (for Schedule Award purposes). As has been previously described, asbestos exposure may have a variety of biological results. While some individuals may never demonstrate any response to the inhaled (or ingested) asbestos particles, the most common (and usually earliest) form of response is the development of abnormalities in the pleural (or parenchymal) tissue which are typically revealed by X-ray. Such pleural plaques or thickening are relatively frequent X-ray findings in exposed populations. Individuals who have this kind of abnormality are often unaware of any problem and do not acknowledge any noticeable related symptoms. Individuals with these findings alone most often do not demonstrate any reduction in lung functions (impairment) when tested. Nonetheless, these individuals (with X-ray indicated abnormality, without impairment or related symptomatology) do have a work-related injury, and are entitled to benefits of the FECA. In addition to payment of related medical expenses and a medical treatment regime, these individuals will be entitled to regular follow-up medical examination (in line with Program Memorandum No. 85). Follow-up examination reports should be closely monitored for progression of the condition.

Simple X-ray indicated abnormalities may also occur in individuals with related symptoms that range from the very mild to the most severe. Usually the degree of impact that these symptoms have on an individual's ability to perform any given effort (disability) will conform to the degree of abnormality or disease revealed on X-ray or as a result of pulmonary function testing. That is to say asbestos-related abnormally or disease may result in measurable reductions in the function of the victim's lungs (impairment) from which observed symptoms derive. This close correlation between symptomatology and impairment is not always the case, however, and relatively mild impairment may be measured in individuals with severe disability and vice-versa.

Measured reduction in lung function is the basis for determination of pulmonary impairment. Since most measures of what constitutes normal function are based on evaluation of "representative" populations divided into categories according to sex, age, and height, actual analysis of an individual's pulmonary function will be based on comparison to some "normal" or "standard" reference. In addition, pulmonary function for any individual varies with age, season, time of day, etc. Therefore, there exists what is generally regarded as a range of normal pulmonary function within which it is said that an individual functions normally. The AMA accepts that pulmonary function (measured by FVC) at or in excess of 85 percent (when compared to normal standards) is, in fact, normal. Reduction in pulmonary function below 85 percent, therefore, constitutes impairment. Reduction in pulmonary function to 34 percent (or less) of standard normal is found only among the most severely ill and is considered to constitute total pulmonary impairment.

Any individual who has sustained an accepted asbestos-related condition which results in pulmonary impairment and who was exposed to injurious levels of asbestos as a Federal civilian employee on or after September 7, 1974, is entitled to a schedule award for permanent impairment of the lungs (refer to Program Memorandum No. 259).

The date of maximum medical improvement will be taken as the date of the examination which provided the results used for computation of the award. It should be noted that, since most asbestos-related disease are progressive, regular reevaluation of claimants who have received schedule awards (or who have accepted cases and were injuriously exposed on or after September 7, 1974) will be required to amend the initial awards because of increased levels of impairment. This can, of course, be done in conjunction with regular follow-up examinations including chest X-ray, pulmonary function studies and other indicated studies. There is no need for reevaluation in cases where the claimant is asymptomatic until such time as he/she becomes symptomatic. Other claimants should be reexamined not less often than once each year unless a different interval is medically indicated.

(2) *Disability Evaluations.* Disability may develop in asbestos-related disease cases in a variety of different ways.

In those cases where asbestos-related disease has progressed to the point that pulmonary impairment is evidenced, an individual may be disabled (either totally

or partially) on the basis of the impairment alone or as a result of the partial impairment in combination with related symptoms (such as dyspnea) which contribute to the restriction of an individual's ability to perform any exercise. In order to determine the degree of disability for work (as opposed to the percent of impairment) it is, of course, necessary to completely and objectively evaluate the individual's ability to perform at levels required by the actual job (as discussed in detail below).

In order to determine the degree of disability for work it is necessary to carefully evaluate the individual's job to determine the actual physical requirements. The required levels of performance for normal work must then be carefully compared to objective measures of the individual's ability to perform. In such cases, proper evaluation of the extent of disability may require additional clinical evaluation and testing. The OWCP consultant specialist may suggest the necessity for obtaining supplemental information as follows:

(a) Medical history and physical examination which indicate an objective and detailed description of dyspnea, palpitation, wheezing, chest pain, orthopnea, paroxysmal, nocturnal dyspnea, the patient's home routine, the effect of symptoms on job performance, the modification of symptoms by treatment regimes, respiration rates and respiratory competency;

(b) Performance of standard or modified exercise tolerance tests; and

(c) Medical opinion—with reference to actual job description and external requirements—regarding the claimant's ability to perform his normal work.

In the above-described circumstances, indicated disability for normal employment exists because of the "exertional" limitations experienced as a result of work-related injury. Because of the nature of some asbestos-related disease (insidious and progressive), it can generally be expected that both impairment and disability are permanent and will get progressively worse.

Although decisions on disability should be made on a case-by-case basis, general guidelines have been developed to standardize the results of disability determinations which indicate that individual is totally disabled on an "exertional" basis. This finding is consistent with the following combination of test results:

(a) X-ray findings of interstitial fibrosis (with or without pleural involvement);

(b) Any two of the following:

(i) FVC=to or less than 55 percent predicted normal;

(ii) DCsb=to or less than 6ml/min/mmHg (or 30 percent precited normal);

(iii) Arterial Blood Gas results equal to or less than values in Table 1 (see Exhibit 4); and

(c) Prognosis.

It should be noted that test results falling within these guidelines almost certainly indicate a reduction in pulmonary competency to a level of total disability for work. Results falling outside of these parameters do not, on the other hand, indicate that an individual is not similarly disabled. This determination must depend on a complete picture of the individual's test results, symptoms and job requirements.

A finding of asbestos-related disease with consequent total disability for work (according to the above-listed criteria) requires initiation of compensation payment for TTD. Similar payment should be made in those cases where OWCP's consultant finds total disability on the basis of exercise test results.

In those cases where partial pulmonary impairment is indicated, normal procedures should be applied in determining any entitlement for LWEC, if the impairment is sufficient to disable the individual for his customary employment.

In those cases where asbestos-related abnormality is indicated but medical evidence does not substantiate the existence of impairment or related disability, the case shall be accepted for diagnosed condition but payment of compensation denied.

(3) *Disability Due to the Hazards of Continued Exposure.*—As held by the Employees' Compensation Appeals Board in the *O'Neill* case (29 ECAB 151) and as clarified in the *Hearn* case (29 ECAB 278), when an employee has suffered a work related injury which results in permanent residuals, there may be disability for work when medical evidence establishes that further exposure to the implicated employment conditions would endanger the employee's health, although the residuals of the injury taken alone might not be disabling. Since exposure to asbestos dust generally results in permanent and irreversible changes in the pulmonary system, in those cases where a diagnosis of asbestos-related disease occurs without disabling pulmonary impairment, or without disability

due to associated symptomatology, medical evidence may be submitted which indicates that continued employment in a certain job (or certain work environment) is contraindicated. That is, a treating physician may find an individual "disabled" for continued normal employment because his job requires (or may place him in an environment which includes) continued exposure to asbestos dust.

In these circumstances, as has been previously noted, exposure to dust levels which conform to the OSHA standard are not considered potentially injurious. However, in some cases medical evidence may be submitted which indicates that exposure to dust levels lower than the OSHA standard, or any exposure, is contraindicated. The employing agency will be required to certify that an individual's normal duties are conducted in an environment which conforms to the OSHA standard or, in the latter case, to the contraindicated level of exposure, or that safety regulations and devices are in place which will ensure such levels of exposure. In either case, when medical evidence of record raises the issue, resolution must be accomplished by a complete medical review by the OWCP consultant specialist.

If continued exposure at any level is contraindicated by medical evidence and if the employing agency cannot certify that the normal employment will take place in an environment that conforms to such level, the claimant will be entitled to compensation for loss of wage-earning capability if reassignment to a safe work environment results in reduced wages or if no such work is available.

h. *Third-Party Action.* Each asbestos case involves potential third party liability because of the product liability issue involved. Each case must be so identified and processed in accordance with established procedures.

19. *Other Occupational Illnesses* not described above will be reported by employees in the several Federal employing establishments. Although the patterns and lists of evidentiary requirements presented above can be modified and applied on a case-by-case basis, there will remain some reports of injury or illness that will fit none of the molds of the categories described above in paragraph 2. These require either sound judgment by the CE, referral to a higher adjudicative authority, or advice from or referral to the Associate Director, DFEC.

MEDICAL HISTORY AND EXAMINATION
FOR ASBESTOS-RELATED DISEASES (Continued)

U. S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Worker's Compensation Programs

MEDICAL HISTORY AND EXAMINATION FOR ASBESTOS-RELATED DISEASES

1. Patient Information

a. Name and Address (City, State, Zip Code)	b. Date of Birth	DOL Claim No.
	c. Telephone (Area Code)	d. Date of Examination

e. Personal Physician (Name and address)	f. Examining Physician (Name)

2. Employment History

(FEDERAL CIVILIAN EMPLOYMENT IN A FACILITY WITH OCCUPATIONAL EXPOSURE TO ASBESTOS)

Location	Your Job	From(Mo/Yr)	To(Mo/Yr)	Asbestos Exposure: Duration	Degree	Frequency

b. Other Employment (NON-FEDERAL)

Company	Your Job	From(Mo/Yr)	To(Mo/Yr)

MEDICAL HISTORY AND EXAMINATION FOR ASBESTOS-RELATED DISEASES (Continued)

3. FAMILY HISTORY

a. Have your parents, children, or other "blood" relatives ever had any of the following:

	YES	NO		YES	NO	If "Yes," identify family member:
1) High blood pressure	☐	☐	6) Asthma	☐	☐	
2) Heart Disease	☐	☐	7) Allergies	☐	☐	
3) Tuberculosis	☐	☐	8) Emphysema	☐	☐	
4) Diabetes	☐	☐	9) Stroke	☐	☐	
5) Cancer	☐	☐	10) Other (Specify)_____	☐	☐	

4. INDIVIDUAL HEALTH HISTORY

a. Have you ever had or been told you have:

	Date	YES	NO		Date	YES	NO
1) Frequent colds		☐	☐	11) Cancer (Location)_____		☐	☐
2) Pneumonia		☐	☐				
3) Pleurisy		☐	☐	12) Diabetes		☐	☐
4) Attacks of Wheezing		☐	☐	13) High blood pressure		☐	☐
5) Tuberculosis		☐	☐	14) Heart Problems		☐	☐
6) Chronic Bronchitis		☐	☐	15) Other (Specify)		☐	☐
7) Bronchial Asthma		☐	☐				
8) Arthritis		☐	☐				
9) Heart Disease		☐	☐				
10) Allergies		☐	☐				

b. Hospitalizations (reasons and dates)

1) Operations_____

2) Serious Illnesses_____

3) Injuries_____

4) Tuberculin Test - (Date)_____ Positive_____ Negative_____

5. SMOKING HISTORY

		Years Smoked
a.	☐ Never Smoked	
b.	Cigarettes: Packs/day	
c.	Pipe: Pipes full/day	
d.	Cigars: number/day	
e.	☐ Stopped Smoking Date:_____	

6. PRESENT ILLNESS (To be completed by examining physician)

a. Chief complaint

Symptom	Duration	Degree	First Noted
1) Cough			
2) Sputum			
3) Wheezing			
4) Dyspnea (exertional)			
5) Hemoptysis			
6) Chest Pain			
7) Orthopnea			
8) Paroxysmal Nocturnal Dyspnea			
9) Ankle Edema			

b) Changes in Endurance (Describe onset, degree and functional limitations and when first noted)

Walking

Climbing

Lifting

Carrying

MEDICAL HISTORY AND EXAMINATION FOR ASBESTOS-RELATED DISEASES (Continued)

7. PHYSICAL EXAMINATION

a. X-abnormal N-normal 0-absent

Physical Exam: 0-absent N-normal X-abnormal (Describe abnormal findings)

General Appearance (Please Describe)

Weight:_____ Height:_____ Age:_____ Sex:_____

Vital Signs: Blood pressure: P/D R:_____ L:_____ Aredomus:_____

Respirations:_____ Temp:_____ Pulse:_____

Head:_____ Eyes:_____

Ears:_____ Nose:_____

Mouth/Throat:_____ Neck: Venous/Pulses:_____

Thorax: A-P Diameter:_____ Thyroid/Trachea:_____

Use of accessory respiratory muscles:_____

Heart: PMI:_____ Pulsations:_____ Thrills:_____ Rhythm:_____

Lungs: Percussion:_____ Auscultation/Adventitious Sounds:_____

Sounds: (Describe)_____

Gallops_____ Murmurs_____

Peripheral Pulses:

Abdomen: Organs_____ Rubs_____

Masses_____ Genito-Urinary - Hernia

Tenderness_____ Rectal/Guiac_____

Sounds_____ Prostate/Gynecological_____

Extremities:

Clubbing_____ Skin/Lymph:_____

Cyanosis_____ Neurological: DTR's_____

Nicotine Stains_____ Nerves_____

Edema_____ Sensory/Motor_____

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MEDICAL HISTORY AND EXAMINATION
FOR ASBESTOS-RELATED DISEASES (Continued)

b. Laboratory/Diagnostic Tests

Complete Blood Count:

Hemoglobin:_____ Hematocrit:_____ White Count:_____

	mcv	mch	mchc	Differential:	neut.	lymphs	monos	Eos	Basos
Indices:									

(Optional) Urinalysis: Sp.Gr._____ pH_____ Appearance_____

Protein_____ Glucose_____ Bile_____

Ketones_____ Micro_____

Other: (If indicated)_____

Pulmonary Functions Studies:

Date:_____ Time:_____ Technician:_____

Instrument Used (name)_____ Paper Speed:_____

Describe patient cooperation and comprehension of instructions:_____

Bronchodilator Used?_____

Results

Efforts:	#1 Predicted	#1 Obs.	#1 %Pred.	#2 Predicted	#2 Obs.	#2 %Pred.	#3 Predicted	#3 Obs.	#3 %Pred.	Best of Three Efforts Predicted	Best of Three Efforts Obs.	Best of Three Efforts %Pred.
FVC (Liters)												
FEV_1 (Liters)												
$\frac{FEV_1}{FVC}$ (FEV%)												
TLC												

Normal Standard Applied:

Arterial Blood Gases - At Rest:

Technician:_____ Date:_____

pO_2:_____ pCO_2:_____

pH:_____

MEDICAL HISTORY AND EXAMINATION
FOR ASBESTOS-RELATED DISEASES

c. Carbon Monoxide Diffusing Capacity (DL_{CO}) - Single Breath Method

Technician:_____ Instrument Used:_____ Date:_____

Estimated Alveolar Volume (Based on Measured FRC)

Results: ml/cm/hg: Actual Value_____ Predicted_____

Normal Standard_____

ECG (Please include tracings):

CHEST X-RAY: PA and Lateral (Additional views if indicated) - PLEASE INCLUDE FULL RADIOLOGIST's REPORT.

BOARD CERTIFIED RADIOLOGIST READING FILMS (Date)_____

DESCRIBE: (1) Quality of Films (2) All Abnormalities and Pathology Present:_____

Especially: (1) Pulmonary Vasculature:_____

(2) Fibrosis:_____

(3) Opacities (size, shape, type, distribution, extent):_____

(4) Pleural thickening, plaques, calcifications, (size, extent):_____

(5) Diaphragm Outline:_____

(6) Cardiac Outline:_____

INTERPRETATIONS:

Above findings confirmed by examining physician?_____

Please make X-rays available for review. DO NOT SEND X-RAYS UNLESS REQUESTED.

Claimant Signature Date

Examining Physician Signature Date

ASBESTOS EXPOSURE SUMMARY

ASBESTOS EXPOSURE SUMMARY

Employee's Name:_____ Location:_____

SSN:_____

Employee No:_____

JOB TITLE	PERIOD		ASBESTOS EXPOSURE			OTHER CHEMICAL OR DUST EXPOSURE				
	FROM	TO	NATURE	DEGREE	FREQUENCY	MATERIAL	NATURE	DEGREE	FREQUENCY	COMMENTS

NATURE OF EXPOSURE:
P=Primary:The individual's normal duties required actual manipulation of asbestos and/or asbestos related products and generated dust.
S=Secondary:The individual's normal duties regularly involved work alongside others primarily exposed or regularly placed him in confined spaces.
I=Intermittent:The individual's normal duties irregularly involved entry into locations where asbestos and/or asbestos products were manipulated.
E=Environmental:The individual's normal duties were performed at a location or facility(such as a shipyard) where asbestos was used but the individual had no normal exposure in excess of ambient levels.

DEGREE OF EXPOSURE:
H=Heavy:Asbestos dust was usually visible in the air.
M=Moderate:Asbestos dust was generally visible on work surfaces but did not cloud the air.
L=Light:Asbestos was used in work area but was generally not visible(although detectable).
A=Ambient:Asbestos levels did not exceed normal levels in the air outside of work spaces.
FREQUENCY OF EXPOSURE: Hours per day.

_____
Authorized Official

Part 2—Claims

OWCP MEDICAL EXAMINATION REQUIREMENTS IN ASBESTOS DISEASE CASES

1. *Occupational History.* Chronological summary of the individual's job history which includes a description of the frequency, degree, and duration of occupational exposures to asbestos with emphasis on exposure in Federal civilian employment, but which includes exposure in non-Federal employment. Include other dusts or toxins and any non-occupational exposure.

2. *Medical History.* Chronological summary which includes references to any previous injuries or illnesses, pulmonary problems and the development of pulmonary symptoms. Summary of pulmonary symptoms. Complete smoking history. Family medical history.

3. *Physical Examination.* To include description of all the following:

a. General appearance and performance;

b. Sex, age, height and weight;

c. Presence or absence of cyanosis, clubbing, nicotine stain, edema, hepatomegaly and exertional limitation;

d. The pattern of claimant's breathing (presence and degree of dyspnea, etc.);

e. Results of cardiac examination;

f. The results of chest examination, including configuration findings on percussion and ausculation and the presence or absence of basilar rales.

4. *Chest X-rays:* Minimum of AP, lateral and R and L oblique views. A full size X-ray shall be taken under the supervision of a board-certified radiologist and read by either a board-certified radiologist or pulmonary specialist. This radiologist's reading must include a description of the quality of the film and all radiographic findings. The examining physician will also review the film for these same purposes.

The X-ray interpretation must include a description of any abnormality or pathology present with special attention given to the presence of pulmonary hypertension, fibrosis, carcinoma, or mesothelioma. If any abnormality or pathology is present, the description must include the following information:

a. Presence or absence of opacities described by type size, shape, distribution and profusion;

b. Presence or absence of pleural thickening, plaques; or calcification, with description of site and extent;

c. Presence or absence of ill-defined diaphramatic or cardiac outlines with description of extent; and

d. Any other findings of past or present problems.

X-rays should be kept available for review on request. Do not send X-rays to this office unless requested. Additional views may be obtained at the discretion of the physician.

5. *Pulmonary Function Studies.* To include measurement of the following functions (the report of the results of the FVC, FEV_1, and Diffusing Capacity must include actual recorded values, the percent of predicted normal, and identification of the normal standard applied for tests conducted before and/or after the use of bronchodilators). These studies should be performed under the supervision or direction of a board-certified pulmonary specialist.

a. Forced Vital Capacity (FVC) and Forced Expiratory Volume in One Second (FEV_1) measured in liters and representing the best of three efforts and the (FEV_1/FVC Ratio (FEV_1 percent) computed from these results. Also include total lung capacity (TLC). Report of the results of these tests must include:

(1) Date and time of the test;

(2) Name, file number, sex, age, weight, and height of the patient;

(3) The names of the technician performing and the physician supervising the test, if different from the referring physician;

(4) A description of the patient's ability to understand and follow instructions and the degree of cooperation in performing the test;

(5) The paper speed and the name of the instrument used;

(6) The date of last calibration of the instrument;

(7) Whether and why a bronchodilator was used and its impact on test results.

The report must be accompanied by appropriately labelled spirometric tracings (for all tests) showing distance per second on the abscissa and distance per liter on the ordinate.

b. *Carbon Monoxide Diffusing Capacity* (Single Breath Method). The results must be reported in ml/mm/mmHg. The report of the test must include estimated alveolar volume (based on measured FRC), the barometric pressure at

the time of the test, the name of the technician performing the test and the instrument used, and the date of last calibration.

c. *Arterial Blood Gas Study,* administrated at rest. A blood gas study may be done during exercise only if not medically contraindicated and if, in the opinion of the examining physician, it is necessary for diagnostic purposes. Report of the ABG study must include recorded values for pCO_2, pO_2, and pH collected simultaneously; the date and time of the test; the altitude and barometric pressure at which the test was conducted; the name of the technician and supervising physician; the pulse rate at the time the blood sample was drawn; the time elapsed between drawing and analysis of the sample; the duration and type of exercise (if appropriate); and a statement indicating that the equipment was calibrated before and after each test.

6. *Electrocardiogram* results submitted with tracings.

7. *Complete blood count.*

8. *Medical Impression and Opinion* which includes:

a. Diagnosis of all pulmonary pathologies;

b. Diagnosis of any other disease condition present;

c. Recommendations regarding indicated course of treatment to improve the level of pulmonary function;

d. A discussion of the findings as regards the indicated degree of pulmonary impairment and exertional limitations (with reference to the enclosed job description); and

e. Discussion of work-relatedness, including a detailed discussion of other possible etiological factors for each of the diagnosed conditions.

TABLE I.—BLOOD GAS TABLE

Arterial pCO^2	Arterial pO^2 equal to or less than (millimeters of mercury)
30 or below	70.
31	69.
32	68.
33	67.
34	66.
35	65.
36	64.
37	63.
38	62.
39	61.
40 to 45	60.
Above 45	Any value.

U.S. DEPARTMENT OF LABOR,
Washington, D.C., September 25, 1980.

FECA PROGRAM MEMORANDUM No. 265

Subject 5 U.S.C. 8103, Medical Policy—Objective Medical Evidence Other Than Physical Examinations.

This Program Memorandum sets forth medical policy as related to tests such as lab, x-ray, electrocardiogram (EKG), electroencephalogram (EEG), electromyogram (EMG), pathology, physiologic tests, including exercise and pulmonary function tests, and others.

1. To be acceptable medical evidence, a test should:

a. Be performed by or under the supervision of a person licensed to perform the test in the jurisdiction in which the test was done; and

b. be documented by a report containing the patient's name, date of the test, the objective data obtained from the test, and the signature of the person responsible for the performance of the test.

2. Where appropriate, the test report should include interpretation by a physician licensed to practice in the jurisdiction in which the test was performed. Tests for which such interpretation is necessary include, but are not limited to, x-ray, EKG, EEG, EMG, cardiac and pulmonary stress tests, pulmonary function tests, biopsy or surgical specimen pathology reports, ultrasound, visual field, oculophles thysmography, echocardiograms, and CAT scans. Laboratory tests giving blood, serum, urine, and spinal fluid contents do not require interpretation by the physician responsible for the performance of the test.

3. Tests requiring voluntary cooperation by the patient, such as visual, hearing, and pulmonary function tests should be accompanied by a comment from the person administering the test on the extent of patient cooperation to estimate the reliability of the test results.

4. Repeat tests may be requested as a matter of practice for those tests requiring laboratory cooperation by the patient, such as visual and hearing tests, repeat tests should also be requested if the result is not within the range of values possible for the tests. If not certain, the claims examiner can check with the District Medical Director (DMD) for confirmation. When the results of two or more different tests have values which appear to be an unlikely combination, the claims examiner should consult the DMD for an opinion on the need for repeat tests. Other tests should be repeated if the above standards are met, except as needed to determine continuing eligibility.

JOHN D. MCLELLAN, Jr.,
Associate Director for Federal Employees' Compensation.

GUIDELINES FOR AGENCIES PARTICIPATING IN LOW BACK PILOT

Your OWCP contact for this pilot is (name and mailing address of medical assistant). If you have any questions, please call _____.

1. When an employee reports a low back injury, prepare a CA–16 with the reverse side crossed out, a CA–28, and a CA–1333. Attach a copy of the employee's position description (or other description of the employee's duties) and a return envelope. Refer the forms to the attending physician for completion. DO NOT issue a CA–17 at this time.

2. Upon receipt of the completed CA–28, submit it, along with a CA–1, a copy of the employee's position description (or other description of the employee's duties), and any other pertinent forms to your OWCP contact named above. (Note: If the CA–28 is not received within 2 weeks, submit other forms to your OWCP contact. Forward the CA–28 when it is received).

3. Monitor the employee as you normally would, but be sure to determine at 21 days after the date of injury whether the employee will return to duty within the next 7 days. If the employee is not returning within 7 days, immediately call your OWCP contact at the telephone number shown above so that a consultant's examination can be scheduled. Otherwise, prepare a CA–3 when the employee returns to duty and forward it to your OWCP contact.

4. A CA–3 should also be submitted to your OWCP contact if the employee returns to duty any time after the CA–1 has been submitted but before the expiration of 21 days from the date of injury or after the employee has been referred to a consultant.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF LOW BACK FORM

Complete items 6 through 20. If additional space is needed for the completion of any of the questions, use the reverse side of the form or attach a continuation sheet.

The form should be returned to the patient's employing agency in the envelope provided.

To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment.

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

LOW BACK FORM

TO BE COMPLETED BY AGENCY	1. Employee's Name	2. Date of Injury	3. Date of Request
	4. SSN	5. File no. if known	

NOTE TO EMPLOYING AGENCY: Attach to this form, the claimant's job description as well as the supervisor's description of the claimant's actual work activities. *(Physical Demands)*

TO BE COMPLETED BY EXAMINING PHYSICIAN (If additional space is needed, please use the reverse of this form) — 6. Date of Examination

7. Brief Description of Injury *(History)*

8. Condition responsible for patient's present symptoms? *(Please check one)*
- A ☐ Low back strain
- B ☐ Herniated lumbar disc
- C ☐ Low back pain *(Use ONLY in first 30 days)*
- D ☐ Other *(Specify)*: _____

9. This condition is a result of: *(Please check one of the following)*
- A ☐ Incident(s) occuring in a 24 hr period
- B ☐ Usual activities over more than 24 hours
- C ☐ Other *(Specify)*: _____

10. Patient's medical condition is: *(Please check one of the following)*
- A ☐ Improving
- B ☐ Stable
- C ☐ Deteriorating
- D ☐ Too recent to evaluate *(Use ONLY in first 30 days)*

11. Which of the following treatment(s) do you recommend? *(Please check all that apply)*
- A ☐ Restriction in activity
- B ☐ Medication
- C ☐ Physical therapy
- D ☐ Surgery
- E ☐ Hospitalization

12. Which of the following treatment(s) has patient received to date?
- A ☐ Restriction in activity
- B ☐ Medication
- C ☐ Physical therapy
- D ☐ Surgery date _____
- E ☐ Hospitalization dates _____

13. Patient is able to perform: *(Please check one)*
- A ☐ Usual work without restrictions
- B ☐ Usual work with restrictions
- C ☐ Lighter work
- D ☐ No work

(Please list restrictions in the space provided on reverse)

14. Patient's return to work is estimated to be
- A ☐ Immediately
- B ☐ 1 Week
- C ☐ 2 Weeks
- D ☐ 1 Month
- E ☐ 2 Months
- F ☐ Other *(Specify)*: _____

If possible, give date patient may return to work _____
Has patient been advised? Yes _____ No _____

15. Patient is to be re-examined in:
- A ☐ 1 Month
- B ☐ 2 Months
- C ☐ As necessary
- D ☐ Other:*(Specify)*: _____

16. Signature of Physician

17. Physician's Name *(Print or Type)* and Professional Degree

18. Physician's Address

19. Specialty

20. Date

Form C
June 1

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
Sedentary — Lifting 0 to 10 Pounds			
Light — Lifting 10 to 20 Pounds			
Moderate — Lifting 20 to 50 Pounds			
Heavy — Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or Working Above Shoulder			
Walking (Hours)			
Standing (Hours)			
Sitting (Hours)			
Stooping (Hours)			
Kneeling (Hours)			
Repeated Bending (Hours)			
Climbing (Hours)			
Operating A Motor Vehicle, Crane, Tractor, Etc.			
Other:			

Please use this space for continuation of reply to any of the questions on the face of this form and indicate the question number to which the continuation refers.

Question number: ____

LOW BACK CONDITIONS—NOTES FOR C.E.'S

Form for low back conditions

1. through 7. Self-explanatory.

8. On the initial form, submitted within 30 days of onset of a low back disorder, the exact diagnosis is not important so long as it reflects an acute mechanical problem (diagnoses 8.A, B, C or "fracture" under D) rather than a degenerative process such as arthritis. The pathophysiology of a low back disorder is often obscure and difficult to diagnose accurately in its acute state. For example, a patient may have a herniated disc that presents initially with pain in the low back and limitation of motion and that is indistinguishable clinically from a musclo-ligamentous low back injury. For this reason the claims examiner needs only to determine that the initial diagnosis reflects an

CONTINUED

2 OF 3

acute mechanical injury and not to concern himself with differentiating between muscular, ligamentous, and intervertebral disc injuries.

A. "Low back strain" is a term for an injury to the back that does not seem to involve the bony structure or the intervertebral discs. Other terms that are sometimes used for the same condition are:

Musculo-ligamentous back injury
Low back injury (type not specified)
Low back sprain

B. "Herniated lumbar disc" is the diagnosis given for low back conditions when the patient has pain radiating into one or both lower extremities, in the distribution of a nerve root, and/or has neurologic deficit of one or both lower extremities (weakness, sensory loss or a change in deep tendon reflexes). Other terms with the same meaning are:

Ruptured disc
Slipped disc
Protruded disc
Herniated nucleus pulposus

C. "Low back pain" will most often be used if there is no clear history of trauma and/or if some other aspect of the patient's history or physical examination suggests a diagnosis other than low back strain or herniated disc (e.g., the patient is known to have had a malignancy and the physician is concerned that the present symptoms may indicate metastatic disease to the spine). Usually this diagnosis will indicate that further diagnostic work-up is planned. The use of this diagnosis beyond the first 30 days is inappropriate and should not be accepted.

D. "Other" is intended primarily for those degenerative conditions that may be claimed as cumulative injuries, e.g., osteoarthritis; or for the rare fracture, e.g., compression fracture, lumbar vertebra. If D is checked, the DMD should be consulted regarding the appropriateness of the diagnosis.

9. This will be the physician's interpretation of the patient's history and should of course corroborate the description of injury in 7 and on the CA–16.

A. The definition of "incident" is the same as the definition of "traumatic injury".

B. "Usual activities over a period of more than 24 hours" refers to habitual or frequent performance of certain activities that are claimed as the cause of a cumulative injury.

10. This question is irrelevant to the initial submission of this form. A patient with an acute low back injury may have considerable fluctuation in symptoms and in any case it is impossible, in the absence of marked neurologic deficit, for a physician to give a meaningful prognosis after the initial examination in most such cases. The question is important, however, after 30 to 60 days as an indication of those cases in which further consultation may be necessary to assure the best treatment and the best chance for the patient's return to work.

11. and 12. If surgery or myelography is planned before 30 days, the case should be referred to the DMD for his opinion regarding the appropriateness of treatment.

13. This assessment of disability is important in its own right, but also, like 11, as indication over time of the patient's medical progress. Details of work restrictions may be given in the full report from the consultant.

COMMENTS ON CASE MANAGEMENT

Receipt of initial CA–28

1. All CA–28's are received initially by the medical assistant (MA) who logs in the form and requests a complete report from the attending physician by sending form letter CA–1340T.

2. The MA checks and if no claim number has been assigned, routes the form to case create.

3. The MA reviews items 7, 8, 9, 11, and 14 on the CA–28 for completeness and takes one or more of the following actions:

A. If items 7 and/or 8 are not completed, sends form letter CA–1337T and no further action is taken until a reply is received.

B. If item 9B or 9C is checked, routes the file to a CE for referral to the DMD or concurrence in the diagnosis or to advise consultation.

C. If item 14 has not been completed, sends a CA–1337T, but continues processing.

D. If item 8D is checked, routes the file to a CE. CE refers file to the DMD for an opinion on the appropriateness of the diagnosis. If the DMD believes that the diagnosis is not appropriate and is unable to clarify the diagnosis after contacting the claimant's physician by telephone or by use of form letter CA–1336T, he will advise consultation.

E. If surgery is recommended in item 11, routes the file to a CE, CE refers file to DMD for opinion on the appropriateness of treatment. DMD clarifies the issue by calling the attending physician.

F. If all the items are completed, the diagnosis is 8A, B, or C, and 9A is checked, the claim is medically acceptable and is routed to a CE for processing.

4. If the agency advises that the patient will not return to work within 30 days, consultation is arranged within a week of the 30 day period with either an orthopedic surgeon or neurosurgeon selected from a register of those specialists who have agreed to see OWCP claimants. The appointment is confirmed in writing to the consultant after telephone clearance, where feasible, with the patient (Form letter CA–1338T). The patient will also receive written confirmation of the appointment (Form letter CA–1335T).

5. The consultant is to complete the medical section of the Low Back Form and return this on the day of examination to OWCP. He is to send copies of his full report to OWCP within one week of examination.

6. When the form CA–28 is returned by the consultant, and the disability is estimated to last 30 days or more and the consultant indicates that the patient should again be seen in consultation in a month, the medical assistant will schedule a second consultation for 30 days after the previous examination and then send the case to the CE. If, however, the consultant recommends repeat consultation at an interval greater or less than one month the CE should review the file, prepare a statement of accepted facts and refer the file to the DMD for his/her advice concerning the appropriateness of the follow-up consultation. The medical assistant will confirm appointments in writing with the consultant and will notify the claimant (Form letters CA–1335T and 1338T).

7. The medical assistant will continue to monitor the claim for receipt of the consultant's narrative report. This report will be attached to the case file and forwarded to the CE.

8. If the consultant feels, however, that the claimant should resume working or should begin a different sort of treatment, the medical assistant should refer the case to a CE on an expedite basis. The CE prepares a statement of accepted facts as necessary, and refers it to the DMD for medical review and opinion. The DMD should be asked to give an opinion on the relative weight of the attending physician's report compared to the consultant's report, taking into account such factors as the medical specialties of the examining physicians, their professional credentials, their knowledge of the actual workplace circumstances and how they relate to the patient's injury or disability, and the internal consistency of the physician's findings and conclusions.

9. If the CE is able to make an affirmative decision based on the medical evidence after receiving the DMD's opinion, the claim should be accepted for continuing benefits. If the evidence negates continuing disability, the CE should prepare a memorandum to the Director with a recommendation for denial of benefits. If, however, the CE is still not able to make a final determination regarding the relative merits of the various medical reports and a decision to continue or terminate benefits, the CE should consult with the supervisory claims examiner and the DMD, and with their concurrence refer the case to a referee, (a board-certified orthopedist or neurosurgeon). This specialist, preferably the head of a university department, should be asked to address the same questions posed to the consultant and the DMD in order to resolve any outstanding medical issues.

Appropriate use of consultants will improve medical care, will expedite the processing of claims, increase the return of employees to the work force, and decrease the costs of low back injuries to the Federal Government.

INSTRUCTION FOR USE OF LOW BACK PILOT FORM LETTERS

1. Ltr. CA–1335T: After obtaining telephone clearances, send to employee to confirm appointment with consultant. Complete by filling in file number, date of injury, medical assistant's telephone number, the consultant's name, address, and telephone number, and the date and hour of the appointment. (For follow-up examinations, strike out will soon in line 1.) Attach SF–1012 and 1012A. Send an information copy to the employing agency.

2. Ltr. CA–1336T: Send to physician who signed CA–28 at address shown in item 18 when DMD believes diagnosis is not appropriate. Complete by filling in file number, date of injury, claimant's name, and employing agency. Attach a return envelope so that response will come directly to the medical assistant. Send an information copy to the employee.

3. Ltr. CA–1337T: Send to physician who signed CA–28 at address shown in item 18 when items 7, 8, or 14 are not completed. Complete by filling in file number, date of injury, claimant's name, employing agency, nad checking the item(s) that are incomplete. Attach a copy of the incomplete CA–28 and a return envelope so that response will come directly to the medical assistance. Send an information copy to the employee.

4. Ltr. CA–1338T: After arranging appointment by telephone, send to consultant to confirm appointment for initial or follow-up consultation. Complete by filling in file number, date of injury, claimant's name, date and hour of appointment, and medical assistant's telephone number. Attach copy of CA–28 received from personal physician, a CA–28 for the consultant's use with blocks 1 through 5 completed, position description, guidelines, and return envelopes so that CA–28 and complete medical report will come directly to the medical assistant.

5. Ltr. CA–1339T: Send to consultant who has agreed to accept OWCP referrals prior to arranging any appointments. Complete by filling in the medical assistant's telephone number. Attach a copy of the guidelines and a sample CA–28.

6. Ltr. CA–1340T: Send to employee's personal physician at the address shown in item 18 when initial CA–28 is received. Complete by filling in file number, date of injury, claimant's name, and employing agency. Attach a return envelope so that response will come directly to medical assistant. Send information copy to employee.

Note: District Office's return address should be shown on all form letters.

LETTER CA–1335T

File No. _____
Date of Injury _____

Our records indicate that you will soon have been disabled for more than 30 days as a result of your work-related injury. Consequently, you are being referred to the medical specialist named below for consultation concerning your diagnosis, disability and treatment, as provided under 5 U.S.C. 8123 of the Federal Employees' Compensation Act.

You should report at the date and time indicated below, as agreed upon in our telephone conversation. If you are unable to keep the appointment, you must notify this Office at least 48 hours before the appointment by calling _____ so that another appointed may be scheduled.

You may claim reimbursement of necessary travel expenses incurred in obtaining this consultation by submitting Standard Form 1012 and 1012A, Travel Voucher, the receipts, to this Office.

Failure to report as scheduled or to notify this Office immediately if unable to keep the appointment will result in a delay in the further processing of your claim.

Sincerely,

Enclosure. District Medical Director.

Physician:
Name _____
Address _____
Phone No. _____

Appointment:
Date _____
Hour _____

LETTER CA–1336T

File No. _____
Date of Injury _____
Claimant's Name _____

The Low Back Form, CA–28, for _____, employee of _____ has been received. The diagnosis you have listed is not one usually associated with low back injuries.

If you do not feel this condition is related to the employee's work, so state on the bottom of this letter, providing reasons for your opinion, and return it to

OWCP. If you do feel the condition is related to the employee's work, please explain this relationship with particular reference to this employee's work activities.

A prompt reply will be appreciated since this claim cannot be processed without this information. A return envelope is enclosed for your convenience.

Sincerely,

Enclosure. District Medical Director.

LETTER CA–1337T

File No. _____
Date of Injury _____
Claimant's Name _____

The Low Back Form, CA–28, for _____, employee of _____ has been received. The following information is missing:

(☐) description of injury (item 7)
(☐) diagnosis (item 8)
(☐) estimated time of return to work (item 14)
(☐) other (item(s))

A copy of the incomplete form is enclosed. Please complete the section indicated and return the form to this Office in the enclosed envelope. Your prompt attention will be appreciated since the claim cannot be fully processed without this information.

Sincerely,

Enclosures. District Medical Director.

LETTER CA–1338T

File No. _____
Date of Injury _____
Claimant's Name _____

Enclosed is the medical material related to the case of _____ who is being referred, as arranged in our telephone conversation, for consultation concerning a low back condition. The patient is scheduled to be seen on _____, at _____. If the patient cancels or fails to keep his/her appointment, please let our staff know at once by calling _____.

Please complete Form CA–28, Low Back Form, and return it to the Office of Workers' Compensation Programs (OWCP) on the day of examination. Your full report, as outlined in the enclosed physician's guidelines, should follow within a week. Return envelopes are enclosed for your use.

Thank you for agreeing to see this patient and for providing OWCP with the medical information needed to assist in a decision on this case.

Sincerely,

Enclosures. District Medical Director.

LETTER CA–1339T

Thank you for agreeing to serve as consultant to the Office of Workers' Compensation Programs (OWCP).

We are referring some claimants to expert medical consultants for their opinions regarding diagnosis, work-relatedness, disability and treatment.

By means of these consultants we wish to obtain unbiased medical opinions, partial to neither employer nor employee, and reflecting the most current knowledge in this field.

Procedure

An employee of OWCP will contact your Office to set up an appointment for the claimant.

If the claimant cancels or fails to keep his/her appointment, please let our staff know at once by calling _____. If your Office is given less than 24-hour notice, you will be paid for the appointment that was not kept.

On the day of the appointment please complete the brief Low Back Form (sample enclosed) and return it to us in the envelope that will be provided. Within a week please send a narrative report, following the enclosed guidelines.

If you have any questions concerning the completion of the form of the requirements for the narrative report, please call me at _____.

Sincerely,

District Medical Director.

Enclosures.

LETTER CA–1340T

File No. _____
Date of Injury _____
Claimant's Name _____

We have received the Low Back Form, CA–28, for _____ employee of _____. We now need a full report on (his/her) present medical condition.

The report should contain the following:

(1) Diagnosis and, if the diagnosis is other than strain, disc or low back pain, you should give medical basis for the diagnosis;

(2) Your opinion on the relation between the diagnosed condition and the particular accident or activity implicated in the condition;

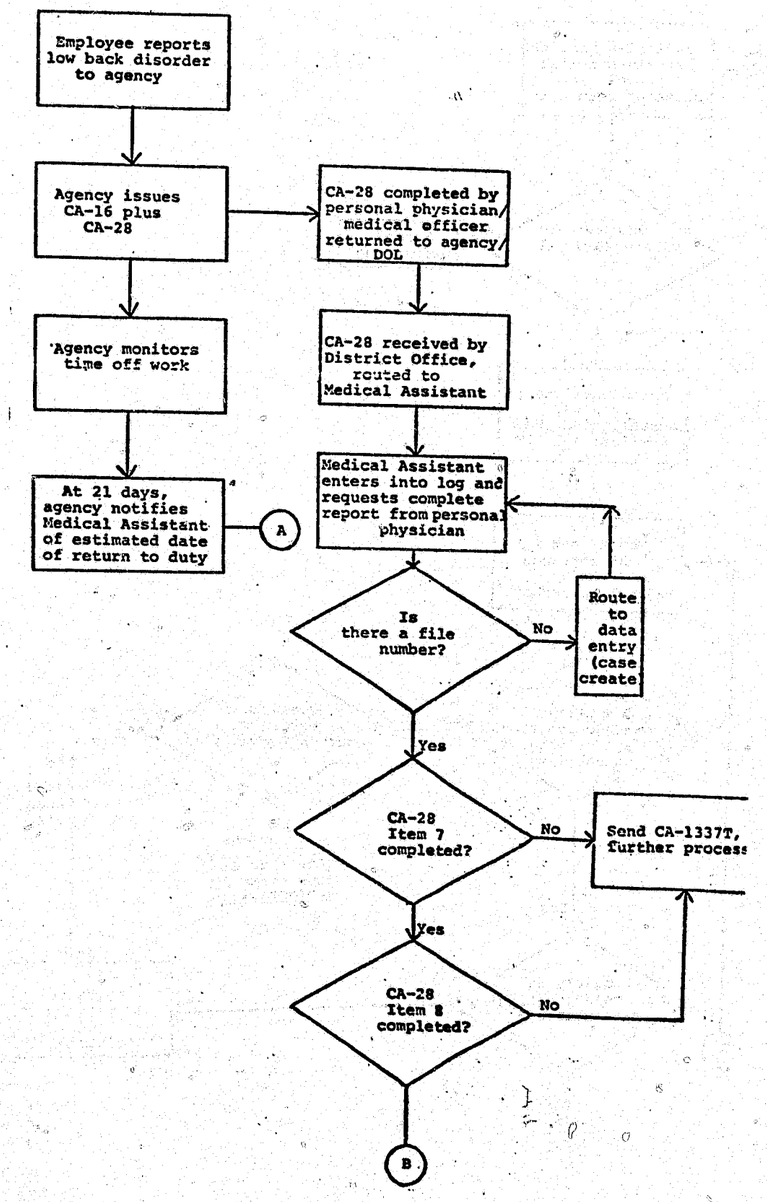
(3) An assessment of impairment due to the work injury and any resulting disability to perform normal work in terms of degree and duration of restrictions and period of disability; and,

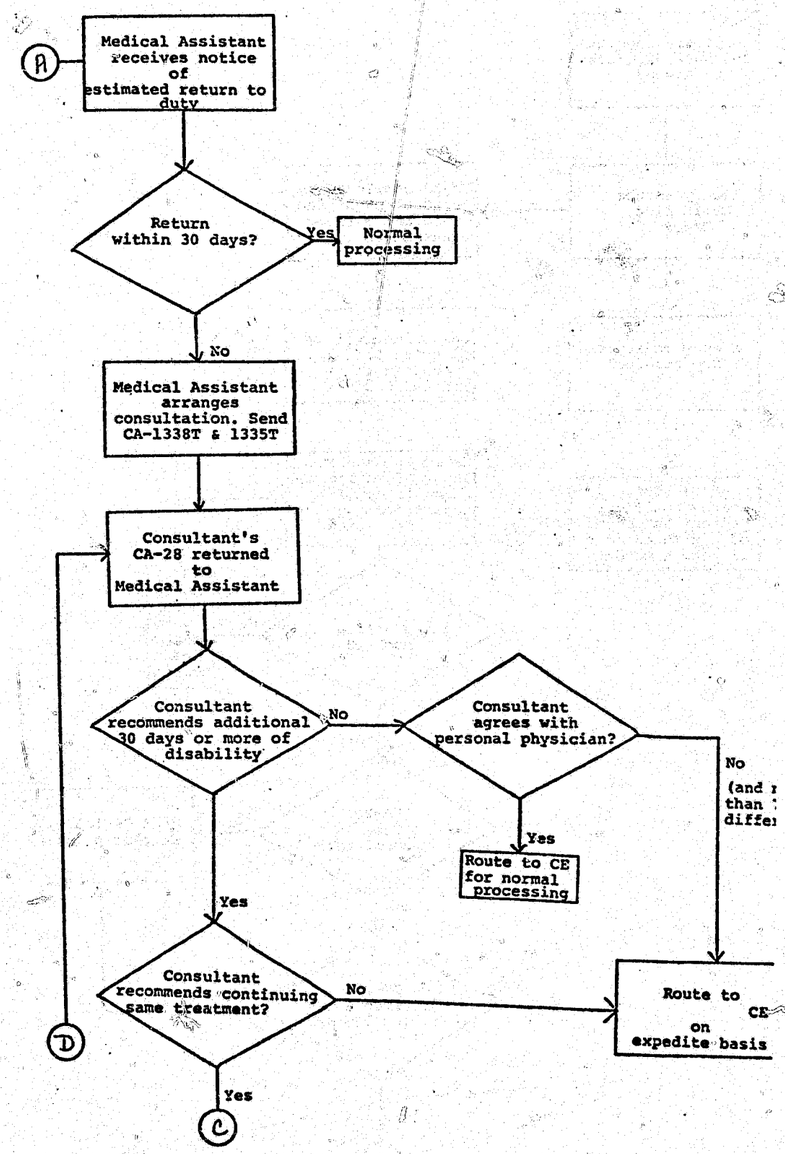
(4) Recommendations for future care.

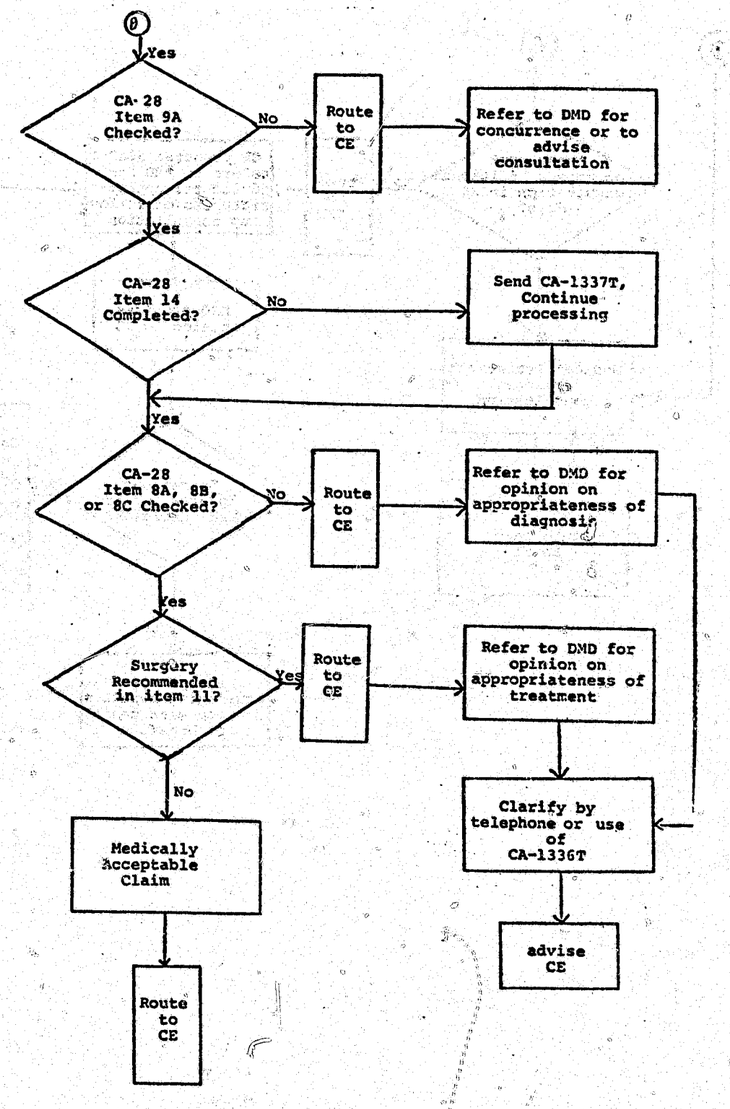
A return envelope is enclosed for your convenience. Your prompt attention will be appreciated since the claim cannot be fully processed without this information.

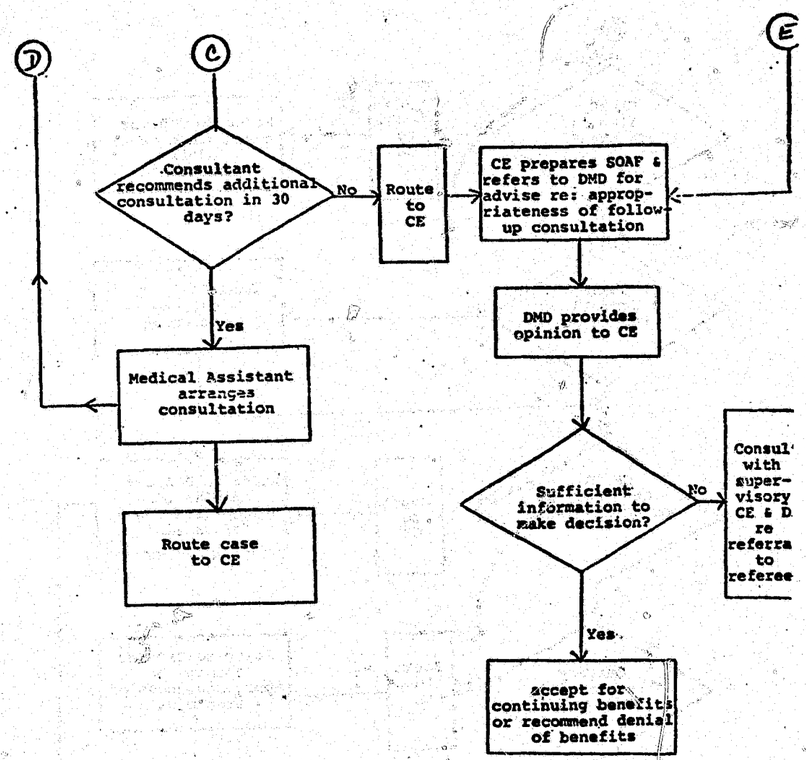
Sincerely,

District Medical Director.




A
Medical Assistant receives notice of estimated return to duty
Return within 30 days?
Yes
Normal processing
No
Medical Assistant arranges consultation. Send CA-1338T & 1335T
Consultant's CA-28 returned to Medical Assistant
Consultant recommends additional 30 days or more of disability
No
Consultant agrees with personal physician?
Yes
Route to CE for normal processing
No
(and
than
diffe
Yes
Consultant recommends continuing same treatment?
No
Route to CE on expedite basis
Yes
D
C


B
Yes
CA-28 Item 9A Checked?
No
Route to CE
Refer to DMD for concurrence or to advise consultation
Yes
CA-28 Item 14 Completed?
No
Send CA-1337T, Continue processing
Yes
CA-28 Item 8A, 8B, or 8C Checked?
No
Route to CE
Refer to DMD for opinion on appropriateness of diagnosis
Yes
Surgery Recommended in item 11?
Yes
Route to CE
Refer to DMD for opinion on appropriateness of treatment
No
Medically Acceptable Claim
Clarify by telephone or use of CA-1336T
advise CE
Route to CE



GUIDELINES FOR THE OWCP NEUROSURGICAL ORTHOPEDIC CONSULTANT

Federal employees with claims for low back disorders will be referred to OWCP neurosurgical or orthopedic consultants for their opinions regarding:

(1) Diagnosis
(2) Work-relatedness
(3) Disability
(4) Treatment

I. Diagnosis

A high percentage of the Federal Workers' Compensation claims are for low back disorders. Most of these claimants relate their symptoms to some discrete incident of trauma. It would expedite the processing of these claims to use as much as possible simple and uniform diagnostic categories. Therefore, where it is appropriate, the conditions listed in Item 6 should be used. "Low Back Strain" is considered synonymous with "Musculo-ligamentous Back Injury." Any difference between "Low Back Strain" and "Low Back Sprain" is considered one of degree rather than of nature of injury. "Herniated Lumbar Disc" is considered appropriate for any case of traumatic low back disorder in which the physician believes there are signs and/or symptoms of lumbar radiculitis but no X-ray evidence of spinal fracture. "Low back pain" may be used if there is no clear history of trauma and/or if some other aspect of the claimant's history or physical examination suggests a diagnosis other than low back strain or herniated disc (e.g., the patient is known to have had a malignancy and you are concerned that the present symptoms may indicate metastatic disease to the spine.) Usually this diagnosis will indicate that further work-up is planned. The use of this diagnosis beyond the first 30 days after injury is not appropriate. "Other" may be used for spinal fractures or for those degenerative conditions that may be claimed to result from repeated trauma but no particular incident, e.g., osteoarthritis of the spine. Also, "other" may be checked if you feel the patient has a condition not properly classified by "strain" or "herniated disc." If this is done the preferred diagnosis must be listed *and* the reasons for this diagnosis given. In your narrative report the reasons for your diagnosis should be enumerated, i.e., you should succinctly list facts from the claimant's history, physical examination and laboratory findings that are essential to the establishment of the diagnosis. Discussion of past history and/or underlying condition are indicated only as they relate to the condition claimed.

II. Work-relatedness

OWCP must have your opinion regarding the relation of the claimant's employment to his/her present symptoms and findings. Has some incident, series of incidents, frequently repeated activity or other physical demand at, or related to, the claimant's work caused, accelerated, precipitated or aggravated the claimant's medical condition sufficiently to account for the present symptoms? We must know in what way and to what extent an alleged accident or activity has resulted in or contributed to the claimant's symptoms. It is necessary that you address the way in which the *particular* accident or activity is related to these symptoms. A general statement about the relation of an activity, e.g., lifting, bending, to low back disorders is not sufficient.

III. Disability

In the Office of Workers Compensation Programs the following distinction is made between *impairment* and *disability*. Impairment is loss of function e.g., limitation of SLR or weakness of dorsiflexion in a patient with a herniated lumbar disc. Disability is inability to perform one's work.

It is important therefore to list the claimant's impairments and then to indicate to what extent each impairment interferes with the claimant's ability to perform his/her particular job. The claimant's job description should accompany him/her and this should be supplemented as necessary by the claimant's own account of his/her work requirements. Special attention should be given to this evaluation. Not only should the degree of disability be specified, but also, where possible, the duration should be indicated or approximated.

According to the Federal Employees' Compensation Act, an employee who sustains a traumatic injury at work may continue to receive his/her salary for 45 days. This law was enacted to assure continuation of pay while a workers' compensation claim is being processed. However, it is not intended to allow 45 days of leave for any work injury. An employee should be advised to return to

work as soon as his medical condition permits. Work restrictions should be specified where they are considered indicated.

IV. Treatment

A consultant should comment on the treatment the claimant has received. He should indicate whether or not he concurs with the treament. If he does not concur he should outline his preferred treatment. In particular, if surgery has been recommended, the consultant should give his opinion regarding the appropriateness of the type of surgical procedure and the timing of this surgery.

Summary

In summary all items on the Low Back Form should be completed and returned to OWCP on the day of examination. Your full report should follow within a week. This report should be complete, but not necessarily long. It should contain only the medical history, examination and laboratory findings which you consider pertinent to the present medical condition. To satisfy the requirements of OWCP it must contian:

(1) Diagnosis and, if the diagnosis is other than strain, disc or low back pain, you should give medical basis for the diagnosis.

(2) Your opinion on the relation between the diagnosed condition and the particular accident or activity implicated in the condition.

(3) An assessment of impairment due to the work injury and any resulting disability to perform normal work in terms of degree and duration of restrictions and period of disability.

(4) An evaluation of the treatment currently prescribed for the patient and your own recommendations for future care.

Management of Claims Based on Severe Acute and Severe Chronic Workplace Stress: Psychiatric Conditions; Cardiac Conditions; Hypertension; Ulcers [1]

A. TIMELINESS

The time limitations in effect on the date of the last incident of workplace stress are those which apply in evaluating the timeliness of the claim.

B. FACT OF INJURY

Certain severe acute or chronic incidents of workplace stress are sufficient external stress to cause a psychiatric condition which is in itself disabling or which may be claimed to be related to psychiatric conditions, cardiac conditions, hypertension, and ulcers.

Severe acute stress incidents occur over a short time period, usually minutes to hours but no more than three days, and must represent an objective or real threat to bodily integrity or personal property:

Threats to life with minimal bodily harm;

Threats to life without actual harm but involving objective, imminent danger;

Physical assault;

Witness to murder, killings, multiple deaths, catastrophic accidents, etc.;

or,

Violent verbal assault or abuse or threatened damage to or loss of personal property.

Severe chronic situational stress incidents occur over three or more weeks:

Forced social isolation, brainwashing, or hostage situations;

Prolonged forced exposure to extremes of cold, heat, dust, wind, noise, etc.;

or,

Incidents of violent verbal assault or abuse or threatened damage to or loss of personal property.

To document the incident(s) of workplace stress, the CE must obtain evidence from the employee, the employer, and, in some cases, witnesses.

1. Evidence From Employee

The employee should submit a statement which answers the following questions:

[1] Does not include claims for psychiatric conditions based on exposure to neurotoxic substances or psychiatric conditions resulting from physical injury.

a. What is the medical condition on which your claim is based? How did it develop and progress?

b. On what date did you first realize the condition was employment related?

c. What was the nature of the workplace stress? Describe the specific incident(s) or factors which influenced the development of the condition (include dates).

d. Were there witnesses? If yes, provide names and telephone numbers.

e. Did you seek any professional help or attention for the condition? If yes, from whom and when (include names, addresses, telephone numbers, and dates)?

f. Are you able to resume work? If no, explain why.

g. Have you ever suffered from this or any similar condition? If yes, provide details, including dates.

h. Briefly describe your personal activities, hobbies, and any other employment.

2. Evidence from Employing Agency

A CA–16 is confirmation of an acute stress incident. In all other cases, the employing agency should provide a statement from the employee's supervisor which answers the following questions:

a. On what date were you notified of the employee's condition?

b. On what date was the employee last exposed to the workplace factors alleged to have led to this condition?

c. What was the nature of the workplace stress? Describe the incident(s) or factors you observed which may have affected the employee. If there are none, say none.

d. Were there witnesses? If yes, provide names and telephone numbers.

e. What effects of alleged workplace stress on the employee did you observe (none, irritability, aggressive behavior, change in productivity, physical complaints, depression, etc.)?

f. What is the nature of the employee's job? Attach an official position description if one is available; if none is available, describe the employee's usual duties and the working conditions (indoor, outdoor, etc).

In all cases, the employing agency should also submit a copy of the employee's application for employment and pre-employment medical examination; copies of all occupational health records; transcript of sick leave usage; and any other pertinent information on the employee's health or prior Federal employment.

3. Evidence from witnesses

If the supervisor does not confirm workplace stress, the CE should obtain statements from individuals who have actual knowledge of the facts. The witnesses should be asked to confirm or refute the claimant's allegations and provide a detailed description of working conditions, the manner in which duties are performed, and the physical and/or mental demands of the position.

C. MEDICAL EVIDENCE

1. Psychiatric conditions

The employee must submit a medical report from a psychiatrist which provides evidence and conclusions, preferably using DSM III, (Diagnostic and Statistical Manual of Mental Disorders, Third Edition) nomenclature criteria. When DSM III nomenclature criteria are used, the report must show that:

a. The employee has one of the following diagnoses on Axis I (clinical conditions): (1) Adjustment Disorder (309.); (2) Somatization Disorder (300.81); (3) Conversion Disorders (300.11); (4) Psychogenic Amnesia (300.12); (5) Psychogenic Fugue (300.13); (6) Post-traumatic Stress Disorder, Acute (300.30); (7) Post-traumatic Stress Disorder, Chronic or Delayed (309.81); or, (8) Psychological Factors Affecting Physical Condition (316.00); and, identifies workplace stress on Axis IV and states that workplace stress was necessary or sufficient to the development of the condition; or

b. The employee has some other diagnosis on Axis I and identifies workplace stress on Axis IV and states that workplace stress aggravated on Axis II disorder.

If the psychiatrist's report does not use DSM III nomenclature criteria, the CE should request an opinion from the DMD on whether the report is sufficient or contact the psychiatrist to see if the diagnosis can be classified under DSM III.

2. Cardiac conditions, hypertension, and ulcers

In addition to the evidence required in C.I., the employee must submit medical records related to the claimed condition and any previous similar conditions, reports on tests, other examinations, treatments, or periods of hospitalization and a current medical report which provides evidence that a physical condition exists and describes onset of the condition, impairment resulting from the condition, and prognosis.

D. BURDEN OF PROOF

The claimant has met the burden of proof and the case can be adjudicated when there is a documented and confirmed incident of workplace stress as described in ---------- does not meet the burden of proof, the claim should be denied.

E. ADJUDICATION

1. Claims based on severe acute stress

Timely-killed claims involving threats of life, physical assault, or witnessing murder, killings, multiple deaths, or catastrophic accidents should receive priority handling since prompt treatment is important. No additional development is needed in these cases to approve immediate short term treatment. The CE should prepare a statement of accepted facts which describes the acute stress incident and workplace conditions and request the DMD's opinion on diagnosis and casuality. Timely follow-up is needed to ensure rapid return to employment.

2. Other claims based on psychiatric conditions

In all other claims involving psychiatric conditions, the CE prepares a statement of accepted facts which describes the workplace stress and answers the following questions:

Was the stress continuous or the result of intermittent or multiple episodes, or was it the result of an acute event?

Is the stress characterized as an objective overwhelming phenomenon or is it best characterized as a perceived stress on the part of the individual?

Did workplace factors, other than specific episodes of stress, intensify or minimize the alleged workplace stressor(s)?

Was the job context supportive, hostile, ambiguous, conflicting?

Had the job included training for stressful event, or was the event totally unexpected?

Did physical factors affect the situation, e.g., extremes of cold, heat, humidity, noise, etc?

The claimant is referred for psychological and psychiatric evaluation as described in F. (The referral for the psychological evaluation can be handled by the DO or by the psychiatric consultant, as the psychiatrist prefers).

The case is medically acceptable if the evaluation report shows an Axis I diagnosis listed in C and the psychiatrist agrees that workplace stress was necessary or sufficient to the development of the condition; or, the report shows another Axis I diagnosis and the psychiatrist agrees that workplace stress aggravated in Axis II disorder.

3. Other claims based on cardiac conditions, hypertension, and ulcers

In addition to the steps taken in E.2., the claimant is referred to an appropriate specialist for a complete medical work-up after receipt of the report on the psychological/psychiatric evaluation. The specialist should be provided with the statement of accepted facts, medical records, and the evaluation report. The specialist's report of this work-up should include:

Occupational history;
Medical history;
Report of physical examination;
X-ray and laboratory results;
Diagnosis;
Recommendations regarding treatment;
Assessment of impairment;
Prognosis; and,

Discussion of the likelihood of workplace stress being a factor in the development of the condition.

If the specialist's report shows that there is a cardiac condition, hypertension, or ulcers and the E.2. evaluation report shows an Axis I diagnosis listed in C and the psychiatrist agrees that workplace stress was necessary or sufficient to the development of the condition, or the report shows another Axis I diagnosis and the psychiatrist agrees that workplace stress aggravated an Axis II disorder, the case, evaluation report, report of medical work-up, and statement of accepted facts are referred to an epidemiologist or a multi-specialist panel for evaluation and opinion on the relationship of workplace stress and the physical condition. The case is medically acceptable if the epidemiologist or panel agrees that there is a relationship.

F. EVALUATION

1. Psychological evaluation

The claimant is referred to a licensed clinical psychologist for objective and projective testing of the claimant's current emotional and intellectual functioning and to identify historical and concurrent stresses in the claimant's life. The psychologist should be provided with the statement of accepted facts, medical reports and correspondence, the claimant's and supervisor's statements, and the position description and authorized to administer the following battery of tests:

Wechsler Adult Intelligence Scale;
Thematic Apperception Test;
Bender-Gestalt;
Draw-a-Person;
MMPI;
Rorshak;
Holmes Stress Scale (scored and unscored);
Any other test the psychologist deems appropriate.

The psychologist's report should answer the following questions, and the conclusions should be illustrated by test data where possible.

a. Differential diagnosis

(1) Is this person suffering from a definable psychiatric disorder, e.g., schizophrenic, effective, anxiety, somatoform, dissociative? Give evidence for such diagnosis from tests.

(2) Assess the severity of any psychopathology and to what degree basic functioning is impaired. For example, is there evidence of thought disorder, delusional activity, impaired reality testing and incapacitating anxiety or depression?

b. Work Impairment

(1) Is this person's psychological function impaired significantly enough to interfere with his ability to work at his/her present job? If so, what is the exact nature of the interference?

(2) Is this individual impaired to an extent which precludes any present employment even if this would entail a major vocational shift? Cite evidence from test data. If another job would be possible, describe its characteristics.

(3) What is the individual's prognosis (estimated length of incapacitation)?

c. Contributing Factors to Work Disability

(1) Based on psychological tests and psychiatric history obtained in interviews, reconstruct a case history of this individual's current disorder. Include psychodynamics which contributed. How directly is this individual's presenting psychological state a reaction to the workplace stress described in the statement of accepted facts?

(2) Do you consider the stressful job-related events sufficient in themselves to result in this degree of disability. If so, why?

(3) Do you consider the stressful job-related events necessary factors in the individual's current disability. If so, why? Relate these factors to any predisposing patient characteristics.

2. Psychiatric evaluation

After the psychological evaluation, the claimant is referred to a psychiatric consultant. The psychiatrist should be provided with the statement of accepted facts, medical reports and correspondence, the claimant's and supervisor's statements, the position description, and the psychologist's report. The psychiatrist

should be authorized to conduct up to three interviews in order to perform a DSM III multiaxial evaluation of the claimant and requested to provide a narrative report which answers the following questions:

a. Diagnostic Evaluation: The Claimant's Psychiatric Condition

(1) Diagnosis: What are the results of a DSM III multiaxial evaluation?
(2) Clinical Evidence: What clinical evidence supports your assessment of the claimant's condition? Include historical information where it is relevant. Include information from the psychiatric examination and psychological testing.
(3) Severity: How severe are the claimant's symptoms now? Assess the severity of any psychopathology and indicate to what degree basic functioning is impaired. For example, is there evidence of a thought disorder, impaired reality testing, incapacitating anxiety or depression?

b. Causality

(1) Non-occupational Factors: What role did non-occupational factors such as family and economic problems and the claimant's documented susceptibility to symptom formation under stressful circumstances take in producing the patient's symptoms. Were these sufficient to have provoked the patient's symptoms? Were they necessary to the development of the psychiatric condition? If yes, describe these factors and how they affected the claimant.
(2) Linkage Between Workplace Stress and Symptom Formation: Did psychological or physiological symptoms occur which, in your opinion, could establish a succession of reactions or responses indicating how the workplace stress as described in the statement of accepted facts led to the development or aggravation of the patient's condition? If yes, indicate what symptoms developed in the course of or subsequent to workplace exposure. Indicate latencies between stress and response.
(3) Impressions—Psychiatric Conclusions Regarding Causality: Do you feel that the workplace stress was a necessary factor in producing the symptoms? (The definition of causalty in this question is a scientific one. Such a concept defines an agent/stress/exposure as a cause only when it can be shown that it was necessary to produce an effect. Scientific concepts of causality do not embrace the notion of a possible influence.) If yes, explain why. If not, why not?

c. Diagnostic Evaluation—Disability

(1) Claimant's Status at the Time of Disability Evaluation: What are the findings on Axis V? Is the claimant's condition stable in that no change effecting work capacity should occur over the next 12 months? If not, is the condition improving or deteriorating? When should a re-evaluation of work capacity be performed?
(2) Assessment of Claimant's Work Capacity:

Is the claimant's psychiatric condition such that he/she cannot perform any work? If yes, why? What functional impairments prevent work? What is the prognosis?

Is the claimant's psychiatric condition such that with the exception of extraordinarily harsh job conditions or stress there is no psychiatric basis for inability to return to the last job held? If yes, explain.

Is the patient's psychiatric condition such that he/she is precluded from performance of the job last held? If yes, for how long and why? What specific job tasks on the last job can the patient not perform? Why? What specific job conditions can the patient not tolerate? Why?

Is the claimant's psychiatric condition such that he/she can perform work other than his/her regular job? If yes, what type of work placement would you recommend?

d. Treatment Evaluation

(Note that the psychiatrist should be advised that treatment covered by OWCP includes medical or psychosocial interventions provided to the claimant to cure, give relief, or reduce the disability associated with the work related condition. Except where the condition is caused de novo by work, treatment goals are limited to restoring the individual to his/her preexisting level of function.)

In addressing this issue, comment on treatment goals and furnish appropriate recommendations.

(1) Treatment Goals: What specific treatment goals for vocational placement can be set for this claimant?
(2) Treatment Recommendation: What treatment would you recommend for this individual? (Include type of medication, psychosocial therapies, and frequency of such treatment.)
(3) Do you recommend a follow-up evaluation by a consulting psychiatrist? If yes, when? (Give date _____) Why: For evaluation of treatment results, work capacity, etc.?

G. MONITORING

As soon as a case is put onto the automatic roll and at the intervals indicated in the psychiatric consultant's report, the case is referred to the DMD. The DMD determines whether there is sufficient medical evidence to support the continuing payment of benefits or whether the claimant should be referred for an examination by a consultant.

QUESTION No. 5

ATLANTA PROJECT

Department of Labor officials testified that OWCP fully supported the Inspector General's Atlanta Project and that a written directive had been issued directing district officials to cooperate with investigators from other agencies who wished to gain access to the claims files of the employees of their respective agencies. Testimony was also received from law enforcement officials from other agencies indicating that the Department of Labor was slow in conducting the administrative follow-up of the results of the project. Please provide detailed information regarding the number of cases referred to the Department of Labor for administrative review, the number of cases reviewed to date, the anticipated completion date of the review and the results of the review to date, including an identification of the number of claimants removed, the number of claimants who will receive a reduction in benefits, and the anticipated cost savings from the review. Also please provide a copy of Mr. Hartman's written directive concerning law enforcement access to district office claims files.

Response

As a result of their study (for which no final report was issued to OWCP by OIG) of the Atlanta Region periodic roll, OIG reviewed 919 cases in which they discovered what they felt were discrepancies. All of these cases have been reviewed and it was determined that, of the 919, no action was necessary in 313 cases. Of the remaining 606 referrals, errors were acknowledged and the appropriate action taken in 424 cases. In 182 cases, OWCP either disagreed with OIG findings or had already instituted the action recommended by OIG. It should be noted that, in the majority of cases, the "errors" discovered by OIG fell into the category of such things as cases not having current medical evidence or not containing a recent (one year old or less) earnings statement. It is not possible at this time to state the total effect in monetary terms of the OIB project. In those cases where errors were acknowledged and appropriate follow-up action taken, the action itself will take some time to bear fruition in the form of dollar savings or compensation.

OWCP productivity reports (Attachment I) show that, using established periodic roll review procedures, 10,080 periodic roll case reviews were performed in the Atlanta region during the period January–July, 1981 as part of the ongoing review process. Of the cases reviewed, compensation was adjusted or terminated in 508 instances, resulting in annual savings of $4,352,124. Nationwide, a total of 2,828 cases had compensation adjusted or terminated as a result of periodic roll reviews. Annual savings for the entire country were approximately $25,000,000. Based on an anticipated average life expectancy of 16 years for each such case, approximately $360 to $576 million in compensation and medical benefits will accrue.

The attached chart (Attachment II) outlines how the OWCP has managed to gain control of its periodic roll and constrain the growth of the roll in the past few years. At present, there are about 48,000 claimants on the periodic roll. Had the trend of 1970–1976 been allowed to continue and the number of periodic roll cases allowed to increase unchecked, the number of claimants on the roll would have been about 56,000 by 1980.

Problems have existed with some OWCP offices in permitting employing agencies to obtain information from FEC files. To alleviate this, Employing Agencies'

right to obtain information from OWCP files was clarified in the FEC Procedure Manual.

To emphasize that employing agencies have a right to access information in OWCP files of its employees, Section 10a was placed in Chapter 2-300 of the FEC Procedure Manual, 9/80.

In regard to the Atlanta OIG project, Labor officials in the Atlanta region were directed by OWCP's National Office to provide full cooperation to the OIG and the other agencies involved. The Atlanta region was also advised by memorandum of February 4, 1981 (Attachment III) to provide full cooperation to the OIG in the loss vulnerability study that was conducted in March of this year.

OWCP endeavors to cooperate with agencies conducting investigations by, among other things, providing access to case files where necessary. The only limiting criteria are that such access to case files be within the parameters of the Privacy Act and Freedom of Information Act. While some problems have arisen in the past (usually due to a question of whether or not access can be given under the Privacy Act, or because investigators demanded access without prior notice), the instructions in the Procedure Manual should preclude similar future problems.

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Rcvd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	
1 BOSTON	14,104	20	2	259	126	132	327,208	249	25	28	49,942	35	---	
2 NEW YORK	21,174	2,754	20	205	147	39	79,935	397	2	17	13,621	28	161	
3 PHILADELPHIA	9,508	2,227	4	113	52	4	35,689	118	2	7	9,221	60	2	
6 JACKSONVILLE	19,611	666	5	477	116	36	115,542	206	22	28	43,332	23	73	
7 NEW ORLEANS	3,487	8	7	18	14	14	1,828	24	---	2	1,198	18	62	
8 CLEVELAND	10,153	465	---	123	101	5	118,114	211	13	55	60,467	10	101	
10 CHICAGO	7,397	6	---	59	72	8	109,394	142	7	10	12,821	17	65	
11 KANSAS CITY	5,024	---	15	15	92	20	45,864	105	1	8	7,211	10	5	
12 DENVER	5,682	325	6	87	54	4	11,303	198	4	3	4,287	10	10	
13 SAN FRANCISCO	63,771	45	13	372	204	51	124,976	145	7	1	5,325	1	6	1,
14 SEATTLE	10,708	1,095	---	27	39	---	---	210	3	8	5,847	34	27	
15 HONOLULU	2,472	157	---	6	6	3	10,787	46	3	---	890	---	---	
16 DALLAS	12,972	600	6	181	74	16	106,367	133	18	15	14,737	88	233	1,
17 ATLANTA	3,486	194	---	35	1	1	1,750	537	15	4	12,306	1	46	
25 WASHINGTON	27,403	1,897	431	139	13	---	---	205	2	29	28,292	46	---	
50 SPECIAL CLAIMS	10,678	41	12	87	12	3	4,261	66	---	7	5,045	5	26	
TOTAL	207,630	10,500	521	2,203	1,123	336	$1,093,018	3,042	124	222	$274,542	386	817	3,

PREPARED BY: OFFICE OF THE DIRECTOR, OWCP

DATE: AUGUST 6, 1981

REMARKS: CASES IN H & R: 2,743
ECAB: 486

ATTACHMENT I

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Recd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	Ca Pend Revi
1 BOSTON	15,037	27	6	311	94	45	176,507	126	38	27	52,108	52	--	--
2 NEW YORK	18,407	3,530	31	105	121	25	35,634	505	--	13	14,107	26	131	3
3 PHILADELPHIA	10,175	1,871	--	94	60	--	--	152	1	2	1,715	19	6	3
6 JACKSONVILLE	22,210	1,425	2	490	84	36	26,595	509	12	20	37,528	66	72	--
7 NEW ORLEANS	3,551	--	--	15	7	7	2,107	83	2	4	6,261	22	69	
9 CLEVELAND	10,283	130	--	112	109	19	142,925	271	20	46	53,253	20	79	32
10 CHICAGO	6,929	5	--	77	52	12	78,859	151	6	17	21,914	16	69	--
11 KANSAS CITY	4,388	--	8	12	73	11	32,112	116	--	3	3,403	7	--	
12 DENVER	5,337	208	11	44	41	--	--	89	3	9	6,981	6	5	15
13 SAN FRANCISCO	45,967	135	26	365	276	43	124,186	338	14	7	13,132	6	14	1,68
14 SEATTLE	8,421	555	--	27	48	--	--	187	8	13	11,636	64	21	28
15 HONOLULU	2,484	10	--	2	7	2	26,321	38	1	--	228	3	--	--
16 DALLAS	13,947	613	8	145	86	34	76,912	257	18	29	31,450	76	304	86
17 ATLANTA	3,251	174	--	24	--	2	36,614	685	21	9	21,944	1	55	64
25 WASHINGTON	26,493	1,625	475	141	10	13	20,799	198	--	2	2,427	17	--	--
50 SPECIAL CLAIMS	11,827	30	6	124	19	2	4,003	167	--	10	5,939	35	30	22
TOTAL	208,707	10,338	573	2,088	1,087	251	$783,574	3,872	144	211	$284,026	436	855	4,25

PREPARED BY: OFFICE OF THE DIRECTOR, OWCP
DATE: JULY 14, 1981

REMARKS: Cases in ECAB: 514
H&R: 2,813

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Re-Issued	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Rcvd.	Third-Party Identified	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	Cases Pending Review
1 BOSTON	14,237	32	9	260	108	122	170,785	125	24	49	62,089	66	---	---
2 NEW YORK	19,423	3,287	20	259	146	25	131,809	769	10	38	36,546	45	156	3
3 PHILADELPHIA	10,544	920	8	66	45	4	22,359	152	2	6	7,028	73	5	
4 JACKSONVILLE	17,938	938	1	475	90	21	47,618	537	19	18	28,882	53	78	---
5 NEW ORLEANS	3,136	-	2	8	16	2	148	59	-	5	6,429	27	67	
6 CLEVELAND	9,208	432	-	111	58	-	-	239	26	51	39,536	4	61	12
7 CHICAGO	7,966	6	-	32	20	4	248,500	169	5	16	17,792	9	64	
KANSAS CITY	4,723	-	1	17	39	9	15,281	87	3	1	3,436	17	-	1
DENVER	4,948	571	5	64	34	3	61,512	124	3	3	3,738	10	11	5
SAN FRANCISCO	37,004	175	21	340	342	18	14,243	578	19	9	18,204	11	13	2,00
SEATTLE	8,357	181	1	36	31	34	55,271	219	5	6	9,983	94	21	27
HONOLULU	2,417	1	-	-	-	-	-	44	-	-	-	3	-	-
DALLAS	12,747	41	12	155	65	8	2,959	291	12	21	26,861	61	200	96
ATLANTA	3,691	158	-	13	1	3	84,085	521	19	5	12,584	-	20	60
WASHINGTON	25,739	1,483	521	90	46	21	3,500	62	-	5	5,864	28	-	-
SPECIAL CLAIMS	12,530	503	15	176	11	2	418	144	-	6	3,011	51	16	26
TOTAL	194,608	8,728	616	2,102	1,052	276	$863,488	4,120	147	239	$301,923	552	712	4,33

PARED BY: OFFICE OF THE DIRECTOR, OWCP

TE: June 5, 1981

REMARKS:

Cases in H & R: 2,592
ECAB: 472

S. DEPARTMENT OF LABOR
MPLOYMENT STANDARDS ADMINISTRATION
FFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Recd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	Cases Pending Review
BOSTON	14,950	34	1	190	136	188	188,091	225	68	25	66,919	72	-	-
NEW YORK	25,217	3,386	19	275	199	30	95,278	720	12	16	15,898	16	135	34
PHILADELPHIA	10,978	1,416	10	96	65	2	2,177	123	2	11	10,547	42	3	8
JACKSONVILLE	19,698	1,569	3	462	83	27	53,985	523	25	14	30,400	44	72	-
NEW ORLEANS	4,060	-	3	13	46	9	24,639	95	-	3	2,355	23	80	3
CLEVELAND	9,749	191	-	90	115	15	41,278	210	16	41	44,177	14	60	365
CHICAGO	7,745	2	-	43	136	13	373,628	141	7	21	30,372	19	84	-
KANSAS CITY	4,676	-	7	17	60	3	20,304	110	1	3	3,033	19	8	5
DENVER	5,968	375	2	47	29	7	23,066	219	3	7	7,666	8	20	80
SAN FRANCISCO	41,286	154	17	362	318	52	130,344	840	26	13	23,137	14	19	2,601
SEATTLE	11,048	291	1	52	38	-	-	239	13	7	14,035	62	26	233
HONOLULU	2,299	8	-	1	4	-	-	42	1	1	1,857	5	-	-
DALLAS	13,624	748	26	166	43	10	37,201	318	21	28	46,701	49	178	1,064
ATLANTA	3,520	105	-	14	-	-	-	1,004	24	19	23,839	2	47	428
WASHINGTON	25,961	1,843	547	158	99	33	125,115	132	6	10	15,097	23	-	-
SPECIAL CLAIMS	11,913	524	27	157	24	3	11,997	97	-	16	17,120	29	18	63
TOTAL	212,692	10,646	663	2,143	1,394	392	$1,127,103	5,038	225	235	$353,153	441	750	4,884

'ARED BY: OFFICE OF THE DIRECTOR; OWCP

TE: MAY 6, 1981

REMARKS: CASES IN ECAB: 487
H&R: 2,467

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Rcd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	Case Pendin Review
1 BOSTON	16,130	--	4	168	140	216	235,823	190	38	39	50,894	96	--	--
2 NEW YORK	19,221	3,774	13	250	262	15	50,826	886	37	21	23,975	26	120	3
3 PHILADELPHIA	6,911	887	19	176	71	10	30,205	161	6	8	10,590	14	6	8
6 JACKSONVILLE	23,695	554	2	492	93	43	61,515	794	21	23	31,589	41	85	--
7 NEW ORLEANS	3,762	--	8	19	28	7	4,053	94	1	1	2,981	27	64	
9 CLEVELAND	11,416	109	--	119	77	9	32,447	199	15	58	61,434	4	66	57
10 CHICAGO	7,523	3	--	42	53	20	105,037	107	5	16	19,611	16	58	--
11 KANSAS CITY	5,446	--	7	20	75	7	40,505	114	2	4	5,571	3	1	1
12 DENVER	6,116	120	7	52	45	7	15,062	188	3	2	3,917	14	5	10
13 SAN FRANCISCO	36,805	111	12	367	297	63	23,745	830	21	11	21,250	11	16	3,44
14 SEATTLE	9,153	253	1	64	38	4	30,046	529	10	4	7,977	60	29	17
15 HONOLULU	2,485	2	--	3	5	--	-----	47	1	-----	745	5	--	--
16 DALLAS	15,098	243	24	173	63	17	14,879	295	14	34	40,195	111	231	1,05
17 ATLANTA	7,369	148	--	51	1	--	-----	1,200	22	11	17,745	--	65	42
25 WASHINGTON	24,953	1,778	736	176	72	43	87,480	178	4	1	2,141	60	-----	--
50 SPECIAL CLAIMS	13,394	92	23	189	33	1	7,705	169	--	6	4,192		11	--
TOTAL	209,407	8,074	856	2,361	1,353	462	739,329	5,981	200	239	304,807	476	757	5,9

PREPARED BY: OFFICE OF THE DIRECTOR, OWCP

DATE: April 6, 1981

REMARKS:

Cases In H & R: 2366
ECAB: 402

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Recd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	Cases Pend Revi
1 BOSTON	14,101	36	14	202	194	109	102,556	105	19	31	36,663	12	—	-
2 NEW YORK	20,835	4,413	18	223	269	18	51,425	518	64	26	29,457	26	55	4
3 PHILADELPHIA	8,837	671	28	147	117	—	—	138	—	7	8,240	47	4	13
6 JACKSONVILLE	18,565	670	—	469	102	26	24,404	603	16	25	39,938	37	78	-
7 NEW ORLEANS	3,431	—	8	19	15	5	1,554	89	1	2	3,774	15	62	
9 CLEVELAND	9,094	109	—	95	17	8	124,898	198	15	62	69,398	1	95	77
10 CHICAGO	6,894	12	—	40	70	14	138,391	131	7	16	20,398	12	61	-
11 KANSAS CITY	5,509	—	3	14	103	5	104,900	107	4	3	5,036	15	—	1
12 DENVER	5,643	88	6	72	22	9	11,146	130	3	—	447	16	24	15
13 SAN FRANCISCO	31,716	348	17	330	234	48	61,422	265	4	1	2,115	4	9	4,27
14 SEATTLE	8,752	334	—	50	34	5	9,361	210	8	3	6,011	84	29	16
15 HONOLULU	2,544	47	—	4	—	—	—	42	1	—	416	1	—	-
16 DALLAS	13,485	508	13	141	83	14	53,104	326	25	20	23,103	28	168	75
17 ATLANTA	3,445	154	—	34	—	—	—	1,284	22	7	14,672	—	153	14
25 WASHINGTON	26,789	1,576	731	210	53	34	62,967	116	2	12	13,750	72	—	—
50 SPECIAL CLAIMS	12,205	161	16	139	6	—	—	27	—	9	3,525	10	2	—
TOTAL	191,845	9,127	854	2,189	1,319	295	$746,128	4,289	195	224	$276,943	360	740	6,75

PREPARED BY: OFFICE OF THE DIRECTOR, OWCP

DATE: MARCH 5, 1981

REMARKS: Cases in H & R: 2,123
ECAB: 444

All D.C. Periodic Roll Cases have been transferr

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FECA WORKLOAD AND PRODUCTIVITY REPORT SUMMARY

OFFICE	MAIL		CA-1420's Released	CONG.	SUBROGATION CASES			PERIODIC ROLL CASE REVIEWS						
	Incoming	Unattached		Phone Calls Recd.	Third-Party Ident.	Third-Party Settled	Amount of $ Recovery	Cases Reviewed	Cases Adjusted	Cases Removed	Monthly $ Savings	Rehab. Refer.	Other Refer.	
1 BOSTON	13,028	63	—	169	244	235	240,443	102	20	20	30,483	40	—	
2 NEW YORK	20,997	3,634	23	232	321	33	78,943	570	5	15	15,509	24	81	
3 PHILADELPHIA	9,057	426	—	152	115	7	9,371	133	5	6	7,243	22	9	
6 JACKSONVILLE	18,860	296	4	382	120	47	32,219	598	24	26	28,840	59	83	
7 NEW ORLEANS	3,293	—	5	7	18	4	179	62	1	3	3,714	15	69	
9 CLEVELAND	9,577	75	—	105	73	9	108,591	240	21	59	67,263	18	64	
10 CHICAGO	7,883	23	—	57	80	11	54,164	142	6	11	13,724	10	62	
11 KANSAS CITY	5,029	—	8	23	63	10	65,398	129	1	5	5,862	22	5	
12 DENVER	5,383	70	6	66	28	4	33,495	137	7	8	9,795	31	18	
13 SAN FRANCISCO	29,661	432	15	309	381	65	136,055	503	9	1	4,657	2	11	4
14 SEATTLE	9,877	227	—	30	40	1	4,666	159	7	4	6,667	88	12	
15 HONOLULU	2,330	113	—	—	2	1	16,658	48	1	—	789	—	—	
16 DALLAS	14,572	344	19	152	101	20	43,465	319	11	20	25,539	31	262	
17 ATLANTA	3,622	107	—	42	—	—	—	1,079	22	15	19,078	2	127	
25 WASHINGTON	24,438	3,310	421	220	65	16	107,200	504	51	11	31,194	82	—	
50 SPECIAL CLAIMS	12,740	187	8	165	25	2	40,555	336	15	13	18,472	13	4	
TOTAL	190,347	9,307	509	2,111	1,676	465	$971,402	5,061	206	217	$288,829	459	807	7

PREPARED BY: OFFICE OF THE DIRECTOR, OWCP

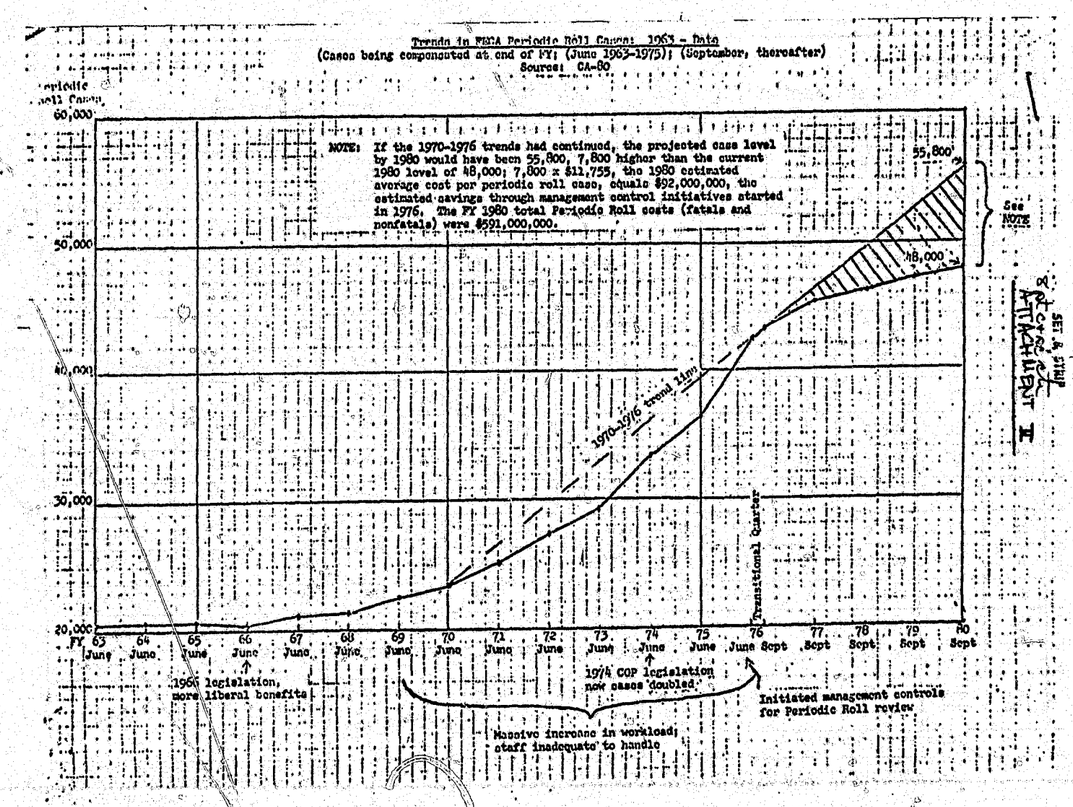
DATE: February 6, 1981

REMARKS:

Cases in H & R: 2135
ECAB: 588

D.C. Periodic Roll Cases: Total:
Schedule Awards:
Other Disability:
Death:

Trends in VETA Periodic Roll Cases: 1963 - Date
(Cases being computed at end of FY: (June 1963-1975); (September, thereafter)
Source: CA-80



SET A STRIP
ATTACHMENT I

Cases Being Compensated on Periodic Rolls

	Total	Nonfatal Total	Schedule Awards	Other Nonfatal	Fatal
June 1963	20,225				
June 1964	20,613				
June 1965	20,649				
June 1966	20,286				
June 1967	21,150				
June 1968	21,230				
June 1969	22,665				
June 1970	23,462				
June 1971	25,149				
June 1972	27,502	18,371	3,015	15,356	9,131
June 1973	29,114	20,231	2,340	17,891	8,883
June 1974	33,244	24,878	3,143	21,735	8,366
June 1975	36,479	28,249	3,923	24,326	8,230
June 1976	42,401	34,077	4,400	29,677	8,324
Sept. 1976 1/	43,376	35,105	4,722	30,383	8,271
Sept. 1977	45,216	37,028	3,611	33,417	8,188
Sept. 1978	46,178	37,999	3,133	34,866	8,179
Sept. 1979	47,318R	39,335	3,056	36,279	7,983
Sept. 1980	47,956	40,043	2,945	37,098	7,913

1/ Change in FY

R - Revised

ATTACHMENT III

Memorandum for Floyd Ansley, Assistant Regional Administrator.
From John D. McLellan, Jr., Associate Director for Federal Employees' Compensation.
Subject OIG Investigation.

The Office of the Inspector General (OIG) is currently conducting an evaluation of FEC Program operations to identify areas of vulnerability to financial loss, fraud or abuse and to recommend potential remedies.

A team of OIG staff (listed in the attachment) will be visiting your Jacksonville district office from March 9, 1981 to March 13, 1981 for the purpose of reviewing and evaluating the following operational areas: Mail/File Processing (Mail/File Unit); Claims Processing (Claims Units); Bill Payments (Fiscal Unit); Manual/Automated Compensation Payments (Fiscal Unit); Computer Security (Systems group).

During this visit, the OIG staff will require work space and facilities (desks, chairs, etc.). In addition, you will need to designate an individual on the district office management staff (preferably the Assistant Deputy Commissioner or the Technical Assistant) to act as liaison with this group for the duration of the visit.

We have instructed the OIG staff to report to ADC Bergerson's office on arrival. Following their introduction and any preliminary discussions you may desire, your designated liaison should provide a tour of the office which identifies each work area, introduces each unit supervisor, and which identifies the work space and facilities provided for their (OIG) use during the week.

Finally, all district office employees should be formally notified of the presence of the OIG staff, the purpose of their visit, and requested to extend every courtesy and full cooperation to these individuals during the week. On their part, the OIG staff will introduce themselves in each instance of interaction with your office staff and will endeavor to limit the demands placed on each employee's time. The OIG staff should, however, be allowed unrestricted access to each work area and all employees (unless, of course, in any individual case this becomes unnecessarily disruptive) for the full week.

Your full cooperation will be sincerely appreciated. If you have any questions regarding this activity, please contact John Fraser (FTS 523–7552) of my staff.

Attachment.

FECA BULLETIN No. 81–30

Issue Date: July 24, 1981.
Expiration Date: July 23, 1982.

SUBJECT

National OIG/FEC Project.

BACKGROUND

In November/December 1980, the Department of Labor's Office of Inspector General (OIG), accompanied by investigative personnel from seven agencies (Air Force, Navy, HHS, VA, DOT, USPS, and Agriculture), conducted a review of approximately 2200 FECA cases in the Atlanta and Jacksonville offices. The purpose of this project was to identify FEC long-term disability cases that should be reviewed by claims examiners for possible reduction in compensation or termination of benefits. While this project was initially limited to the district offices in the Atlanta region, it has now been decided, through agreement with the Director, OWCP, that such a review should be done nationally.

PURPOSE AND SCOPE

To notify appropriate District Office personnel of the impending OIG/FEC project which will take place on a national scale and to provide general instructions for the implementation of same.

APPLICABILITY

Appropriate National and District Office personnel.

ACTION

OWCP Deputy Commissioners (ARA's) should anticipate being contacted by the OIG Regional Special Agent-In-Charge within the next 30 days. The purpose of this contact will be to set a date for a joint meeting between OWCP regional

personnel and OIG regional agents along with representatives from the participating agencies. At the meeting, scheduling of the OIG file review and associated logistics will be discussed.

1. Preparatory to the actual review, district office personnel should make the arrangements with regard to:

a. Working Space: If the OIG regional office cannot provide adequate space for the review team to work, OWCP should then make every attempt to do so.

b. Records: The OIG review team will be provided with a case listing for each district office, by the National Office. Each district will be required to provide the OIG review team with a copy of their Department/Agency file (FECS). A copy of the case listing provided to OIG will be forwarded under separate cover.

c. Case Files: A system for controlling the flow of files to and from the review team should be established. The method and type of control is at the discretion of the district office, but should be sufficient to track each case and eliminate the possibility of loss of any case.

d. Training: No review of FECA case files will be conducted by OIG or Agency investigators who have not received preliminary training on the FECA. Each district office is responsible for providing such training. The training should not exceed 12 hours in length and should be delivered by qualified district office personnel. The training should be more in the nature of an overview rather than an indepth study. A suggested training course outline and text has been provided as an attachment to this bulletin. While it is not necessary that the district offices strictly adhere to the suggested format, certain subject areas have been specifically requested by the OIG. Therefore, regardless of how this training is delivered, it should include the following topics: Five Basic Requirements, Schedule Awards, Dual Benefits, Quality Control Review, and the CA–800. It is also extremely important that the training and orientation provided to OIG staff emphasize that the case listings that they are working from were produced prior to their review and that they should, therefore, verify that the case continues on the Periodic Roll at the time of their review before conducting an evaluation.

e. Technical Assistance: A senior claims examiner should be made available on an on-call basis, to answer questions and/or provide technical assistance to the review team. Such assistance may be general in nature or on specific cases.

2. Action Subsequent to OIG Review:

a. For each case reviewed, the OIG or agency investigator will complete a review form which identifies the case and any findings of the review. A copy of this form will remain with the case, a second will be retained by the Regional Special Agent-In-Charge, and a third will be forwarded to the OIG National Office. As each case reviewed is released by OIG (review completed) the following actions must be taken:

i. The case, with the completed review form, should be reviewed by designated FEC Program staff for both record-keeping purposes (see item 2b below) and to determine whether follow-up action is required as a result of OIG findings.

ii. On all cases with OIG findings/recommendations for follow-up indicated on the review form, this initial Program review should result in either (a) the scheduling of appropriate follow-up or (b) completion of Part 3 of the form by the FEC reviewer clearly stating why the case does not require follow-up on the basis of OIG/agency investigator findings or recommendations. If this latter course is taken (completion of Part 3) on initial FEC review, copies of the completed review form should be mailed to both the Regional Special Agent-In-Charge (who will provide the appropriate address) and to the OIG National Office (address below).

iii. Copies which are scheduled for follow-up as a result of this initial FEC Program review should be routed to appropriate Program personnel for action as scheduled (e.g., obtain current CA–1032, medical report, etc.). As this action is taken, Part 2 of the review form should be completed by responsible Program staff and copies mailed to both the Regional and National OIG offices (the original being retained in file). In no case should such indicated follow-up action be scheduled for completion more than 30 (calendar) days after completion of the OIG review.

iv. Finally, once final results on the indicated follow-up action have been achieved (e.g., WEC performed, termination, CA–1032 or medical report

received substantiating continued eligibility, etc.), Part 3 of the review form shall be completed and copies mailed to both the Regional and National OIG offices as above.

Note: Original copies of the OIG review form are retained in the case folder and only filed down when Part 3 is completed and copies have been mailed to the appropriate OIG offices or if no findings suggesting follow-up are reported by the OIG/Agency investigator conducting the review.

b. Each district office should submit a report to my attention at the conclusion of the OIG review. The report should include the following items in summary form:

i. Total number of cases reviewed by OIG team;
ii. Total number of discrepancies reported by OIG, broken down by type (i.e., lack of medical evidence, outdated CA–1032, evidence of earnings, etc.);
iii. Total number of cases on which actions are recommended by OIG, by type;
iv. Total number of actions taken by district office by type; and
v. Total number of OIG recommendations in which the district office disagreed.

c. The address to which completed copies of the case review forms are mailed is: Department of Labor, Office of Inspector General—Investigations, ATTN: Mr. P. D. Nichols, Room S5612, Frances Perkins Building, 200 Constitution Avenue NW, Washington, D.C. 20210.

Disposition: This bulletin is cancelled when all of the above action items have been accomplished.

JOHN D. MCLELLAN, Jr.,
Associate Director for Federal Employees' Compensation.

Distribution: List No. 6—(Regional Administrators, Deputy Commissioners, Assistant Deputy Commissioners, Systems Managers, Technical Advisors, and National Office Staff).

FECA INFORMATION COURSE FOR OIG AGENTS COURSE OUTLINE

I. Introductions.
II. Basic FECA Information:
  A. Five Basic Requirements:
    1. Time;
    2. Civil Employee;
    3. Fact of Injury;
    4. Performance of Duty;
    5. Casual Relationship.
  B. Entitlements and Benefits:
    1. Medical,
    2. Disability:
      (a) Temporary Total;
      (b) Permanent Total;
      (c) Permanent Partial/Temporary Partial;
      (d) Schedule Awards.
    3. Death Benefits;
    4. Vocational Rehabilitation;
    5. Attendant's Allowance;
    6. Cost-of-Living Increase;
    7. Third Party.
  C. Continuation of Pay:
    1. Dates of Eligibility;
    2. Counting Days;
    3. Controversion;
    4. Termination.
III. Forms Review:
  A. CA–1;
  B. CA–2;
  D. CA–3;
  E. CA–4 and 7;
  F. CA–8;
  G. CA–16;
  H. CA–17.

IV. Adjudication Process:
  A. Five Basics met;
  B. Period of Disability;
  C. Daily Roll and Automatic Roll;
  D. Buy-Back Procedures;
  E. CA–800;
  F. Quality Control Review (for Period roll cases);
  G. Loss of Wage Earning Capacity (LWEC).

LIST OF COMMON ABBREVIATIONS

CS—Compensation Specialist
COP—Continuation of Pay
CSC—Civil Service Commission
DOI—Date of Injury
DOL—Department of Labor
FECA—Federal Employees' Compensation Act
LWOP—Leave Without Pay
OWCP—Office of Worker's Compensation Programs
RTW—Return to Work

I. INTRODUCTION

A general discussion of what will be covered in the short course.

A. Purpose of the course:

As an agent for the Department of Labor, Office of the Inspector General (DOL/OIG) you will be called upon to review FECA case files and meet with Division of Federal Employees' Compensation (DFEC) personnel. In reviewing case files and conducting these interviews, it is essential that you have a basic understanding of the parameters within which FECA claims are adjudicated. These parameters consist primarily of the evidential burdens imposed by law. This course is designed to give you such an understanding. It is an in-depth overview of the FECA. It will not make you expert examiners or technicians, nor is it designed to do so. If you leave this course feeling that you can review a case file with more definity and less superfluous action, then we have all spent our time well.

II. BASIC FECA INFORMATION

A. Five Basic Requirements

1. Time limitations

The law requires the employee to give written notice of injury and file (or have filed for in claimant's behalf) a claim within a specified period of time. This is done in order to protect the employee from protracted liability and to encourage prompt development and investigation of claims.

The time requirements for filing written claim have changed over the years through amendments to the FECA. The time requirements in each case are measured from the end of the day of injury. Apply the law as written on the date of injury.

When determining whether a claim has been timely filed it is important that you not only apply the law as written on date of injury, but you must remember that there are two types of injury: Traumatic injury and Occupational disease.

When does "time begin to run"? (Determine the date of Injury—DOI).

In case of traumatic injury, where there is a single traumatic incident definite as to time, place and circumstances, "time begins to run" from COB (close of business) on the date of injury.

Where there is no single fortuitous event and a condition arises gradually with no particular happening to attribute it to, it falls under the category of occupational disease. In the case of disease (including hearing loss), "time" begins on the last date of exposure to the employment conditions believed to be the cause; or when the employee is aware (or, by the exercise of reasonable diligence, should have been aware) of a possible causal relationship between the disease and the job, whichever is later.

The Appeals Board has interpreted the phrase "reasonably should have known" as: the claimant just needs to be aware of an impairment, and its possible relationship to employment; the claimant does NOT have to know either the EXTENT of disability or the permanency of impairment to exercise reasonable diligence in filing a claim.

In the case of death, "time begins to run" from COB on the date of death (DOD).

Time does not "begin to run" if a person:

Is a minor, until he or she reaches age 21 or is appointed legal guardian.

Is incompetent (e.g., mentally or physically—in a coma) and/or has no duly appointed legal representative.

(After 9/7/74) Fails to give written notice because of exceptional circumstances.

Note that volunteers are covered under the Act (see program memo 127) temporary and part-time employees are covered. Handled primarily by "Special Claims" (D.O. #50).

One very large group of federal employees, military personnel, are excluded as they are covered by separate legislation. Also not covered under the Act are contract employees (persons employed by a Federal Contractor).

USPS Maintenance Contract—employees may or may not be covered, usually occurs with contract cleaners used by the Post Office.

C. *Fact of Injury*

The third "basic requirement" a claim must meet is "fact of injury". The question "Did an injury (or disease) in fact occur"? It is often a judgment issue. If "fact of injury" (FOI) cannot be established, then the case can be thrown out (denied; a rarity when bases only upon "fact of injury"). When FOI is established based upon "factual evidence, the casual relationship" becomes a serious consideration.

In determining "fact of injury", the Claims Examiner (CE) has to resolve two key issues:

(1) Whether the "injury" is a traumatic injury, an occupational disease, or the aggravation of a pre-existing condition.

(2) If it is a traumatic injury, whether the incident being reported in fact occurred in the time, place and manner alleged.

INJURY vs. DISEASE

"Injury" is defined by FECA 8101(5) as: "includes, in addition to injury by accident, a disease proximately caused by the employment . . ."

Traumatic injury is defined as: a wound or other condition of the body caused by time and place of occurrence and by member or function of the body affected; and be caused by a specific event or incident or series of events or incidents within a single day or work shift.

FECA now provides, in the definition of "injury", for damage to and destruction of medical braces, artificial hands and other prosthetic devices or appliances (except eyeglasses and hearing aids). Prior to September 7, 1974, the damage to medical braces, artificial hands and other prosthetic devices was not compensable. These appliances will be replaced or repaired on a one time basis and the employee is entitled to continuation of pay (COP) while absent from work to have this done. Eyegl sses and hearing aids may also be replaced or repaired if they were damaged incidental to a personal injury to the body that required medical attention.

Occupational disease or illness is distinguished from "traumatic injury" in that, in the former, exposure to environmental factors or agents is the critical issue. That is, while a traumatic injury is sort of an "one-shot deal", a disease is characterized by continued and repeated exposure to conditions of the work environment over a longer period of time (2 days or more).

Exposure depends upon the type of case, for instance: hearing loss; TB; skin disease; systemic infections; continued or repeated stress and strain or friction; exposure to chemicals, toxins, poison, smoke, fumes, silicosis or asbestosis, etc.

For occupational disease cases, you must establish that due to conditions of employment, claimant was, in fact, exposed to certain elements that (because of their amount, volume, density or duration) could cause an occupational disease. Further, there must be evidence that the disease exists (not just exposure to disease) when the claim is filed.

D. *Performance of Duty*

The determination of "performance of duty" is an issue that applies only to traumatic injury claims. Basically, what you are trying to determine is that the incident resulting in an injury arose out of, and was in performance of the duties for which the employee was hired by the Federal Government.

The "performance of duty" question can be broken down generally into two main issues:

1. DID THE INJURY ARISE OUT OF THE EMPLOYMENT?
a. The "industrial premises" rule
b. "Proximity Rule"
c. To and from work
d. Idiopathic falls
2. DID THE INJURY OCCUR IN THE LINE (PERFORMANCE) OF DUTY?
a. Diversions from duty
b. Statutory exclusions

The claimant is said to be "in performance of duty" (and therefore covered by the FECA) when both issues can be answered affirmatively. If either issue is not acceptable, then it can be said that the injury did not occur in "performance of duty". The "burden of proof" is on the claimant to demonstrate that the injury occurred in the performance of duty.

I. DID THE INJURY OCCUR ON PREMISES?

A. The "industrial premises" rule

When an injury occurs on the premises of the employer during normal working hours, the employee is entitled to compensation benefits, even though the injury did not arise out of specific work. Additionally, implicit in this rule, an employee is usually covered for an injury that occurs on premises:

For a reasonable time (e.g., says, a half hour) before and after work.

While the employee is performing duties incidental to the job (e.g., getting coffee or food on break or lunch; getting a drink of water; going to the restroom; etc.) or performing an accepted practice of employment (e.g., obtaining supplies from a shelf; relaxing in an employment lounge, etc.).

The "industrial premises" rule works differently depending upon the claimant's "duty status", as follows:

1. Employees Who Work Fixed Hours in a Fixed Place of Work

(a) If the injury occurs on the premises (e.g., property owned, operated or controlled by the federal government), then the claim is probably acceptable. If this criterion is met, you would then examine the second POD issue.

(b) If the injury did not occur on the premises, then you need information from the Supervisor explaining why the employee was not on premises.

(1) Legitimate duty (e.g., official government business or errands) off-premises is covered.

(2) Off-premises lunches are not covered even if there is an unofficial policy that employees not eat at their desks and even if there are no lunchroom facilities on the premises.

2. Employees Who Have No Fixed Hours and/or No Fixed Place of Work (E.g., Letter Carriers, Fire Fighters, Police, Etc.)

(a) If there is no deviation from the assigned route (e.g., the route agreed to by prior arrangement with the supervisor), then the claim is probably acceptable.

(b) If there is a diviation from an assigned route (e.g., during a regular lunch or route), then an explanation is needed, before a determination can be made.

(1) Usually considered in POD to and from the route if employee leaves the route for a reason that benefits the Agency and is not purely personal in nature.

(c) If the injury occurs while on-call or stand-by, then it is probably acceptable.

3. Employees on DY ("temporary duty")

Employees are staying in non-government quarters.

(a) Covered 24 hours a day for any activity reasonably incidental to the TDY. Example: Sightseeing, visits within a "short" distance, injuries in a hotel, restaurant, movies, etc.; recreational activities that could be expected when one is away from home (e.g., swimming in the hotel pool).

(b) "Rule of thumb"—person is covered if injured in the course of doing whatever the employee might normally do when on regular duty on-premises, or actions can be construed as those a "reasonably prudent individual" might take.

4. "Bunkhouse rule"

Employees are staying in government furnished housing (e.g., Cadets, Job Corps enrolles, VA, Public Health, Seaman, etc.)

(a) Covered for activity reasonably incidential to performance of duty or during an accepted practice of employment.

(b) "Performance of duty" might include employees not working or not at their regular duty station (but not if they are at home).

(c) covered when the injury may be caused by living in close quarters (i.e., stress or friction between roommates).

(d) Job Corps enrollees are not covered for injuries that occur at their home, whether or not they are on a pass or on leave.

NOTE.—Employees are covered under the "bunkhouse rule" only if they are living in the government housing because same requirement of the job or for the convenience of employer.

B. "Proximity rule"

An employee who has a fixed place of employment generally is not in the performance of duty when the injury occurs off the employer's premises, however, the "proximity rule" is an exception.

"Proximity rule" concerns those cases where the industrial premises are constructively extended to incompass a hazardous condition proximate to the premises, and considered to be hazardous of the employment, as distinguished from a hazard which is not peculiar to employer's premises.

C. To and from work

In general, FECA protection stops when the employee leaves the premises; the employee is usually not entitled to compensation for injuries sustained while going to and from work, except in the following situations;

1. The employer furnishes the means of transportation.—For example, the Postal Service provides for the carrier to use a postal vehicle and allows him or her to drive back and forth to work.

2. The employee is required to drive a vehicle while on official business.—For example, rural carriers in some areas are required to use their own automobiles to deliver the mail. These employees are covered from the time they leave their residence until they return home again at the end of their tour.

3. Employee is subject to emergency and is responding to one.—For example, a fire fighter, at home, is called in because of an emergency and is involved in an auto accident on the way to the employment site.

4. *The employee is on official travel status (TDY).*—For example, an employee whose permanent station is located in Nek York City has been assigned to work in Washington, D.C. for a period of 30 days. The employee has coverage from the time he or she leaves the office or residence in route to the airport. This protection continues 24 hours a day until the temporary detail is concluded and the employee returns to New York City, either to his or her residence or office. The employee would lose protection of the FECA if only one of the specific statutory exclusions applies or if the employee were to deviate from the general locale or temporary station. (For example, coverage would be suspended if the employee decided to go to Ocean City for the weekend. Coverage would stop when the employee departed from the metropolitan area of Washington, D.C., and would not be resumed until he or she returned to the temporary duty station hotel.)

5. *The employee is taking home official government business.*—(e.g., work must have been assigned by the official superior—not just extra work taken home at the employee's initiative), or is called in by the Agency to work on a special assignment or project.

D. Idiopathic falls

A fall caused by a personal condition (e.g., epilepsy, heart attack, diabetes, etc.) and not caused by an external object or factor, (e.g., a slip or a trip).

1. Covered if: Claimant hits something (e.g., desk) on the way down and/or the fall is "unexplained" (e.g., a faint or black-out; no known preexisting condition)—the claimant is covered, but only for the results of the fall. For example, if the claimant has a pre-existing condition and passes out, hitting a drawer on the way down and resulting in a head injury, and not for the pre-existing condition that caused the fall.

2. Not covered if: Claimant hits the floor only and has an "explained" fall (e.g., has a pre-existing condition and the condition caused the fall).

II. DID THE INJURY OCCUR IN THE LINE OR DUTY?

The test of whether an injury occurs in the performance of duty is generally whether the injury arose out of and was in the course of employment. The term "in the course of employment" means simply that the injury occurred while working. "Arising out of employment" means that there is "causal relationship" between a work experience and the injury. There are situations where an injury occurs in the course of an employment but does not arise out of employment. For example, a postmaster in a small town in Oklahoma filed a claim for acid burns on the face and loss of vision. This claim is based on an injury sustained by the postmaster while he was working at the stamp window. Someone came up to the window and threw acid in his face. Development of the factual evidence revealed that there was a personal relationship between the postmaster and the patron. Although the injury occurred during the course of employment, it actually arose out of a personal difficulty, not the employment. Therefore, the injury was not compensable under FECA. Some injuries may or may not be covered, depending upon the type of diversion resulted in the injury.

A. Diversion from duty

There seem to be 6 major types of "diversions".

1. Horseplay (e.g., "rough-house" or "kidding around")

(a) Usually covered if:

(1) close or confining quarters;

(2) working together over a long period of time;

(3) long absences from home;

(4) related to work environment (e.g., "playing around" while performing a job).

2. Assault

(a) Usually covered if:

(1) accidental or random, or committed by an insane person if employment caused the claimant to be at the particular place at the particular time of the assault;

(2) Assault arises directly out of employment factors (e.g., an attempt to rob the employee).

(b) Usually not covered if:

Assault arises out of personal matters unrelated to the job, and it cannot be shown that the assault was materially substantially aggravated by employment.

3. Recreational Activities

(a) Usually covered if:

(1) INFORMAL—employee is on premises during lunch or break (e.g., throwing frisbees)

(2) FORMAL—an organized event that:

Is part of the job (e.g., recreation with patients on premises)

Agency derives a "tangible" or material benefit: the event meets Agency needs; the Agency contributes to the activity (e.g., offers space or financial support or time to participate); the agency encourages participation in the acivity.

(b) Usually not covered if:

(1) Recreational activity is not part of the job.

(2) Agency does not derive a "tangible" benefit (e.g., team softball after hours or on Saturday, but not officially sanctioned or sponsored by the Agency)—Agency does not contribute to the activity or encourage participation; event is voluntary and for the employee's benefit.

(3) Personal recreation off-premises on lunch or break (e.g., jogging).

(4) Emergencies (a) "Good samaritan"

(5) Personal Activities

(a) Usually covered if: Permission is given by the Agency, and injury arises out of factors of employment.

(b) Usually not covered if: Permission is not given (or needed) by the Agency (e.g., running personal errands on lunch hour); or permission is given, but injury does not arise out of factors of employment.

(6) Violations of a Safety Act
(a) Usually covered if:
(1) Rule is not stringently enforced.
(2) No warnings were given.
(3) Carelessness.
(4) Negligence (NOTE: Simple negligence is not a bar to compensation).
(b) Usually not covered if:
(1) Rule was stringently enforced.
(2) Claimant had frequent warnings.
(3) Intentional or deliberate negligence (e.g., refusing to wear safety equipment)—must be proved.

B. *Statutory exclusions*

Difficult to prove; it is the employer's burden to do so, if proved, no entitlement of any kind under the Act. These statutory exclusions are as follows:

1. Willful Misconduct

Willful misconduct is limited to a serious and deliberate violation of known regulations. Misconduct which results from carelessness, inadvertance, thoughtlessness, inattention, distraction or negligence does not come within the meaning of the term "willful misconduct". In most instances, "horseplay" (rough or boisterous play) and fights among co-workers do not constitute willful misconduct. These actions are a normal consequence to be expected when a group of workers are thrown into personal association for an extended period of time. Regardless of the circumstances surrounding horseplay or a fight, injury to an innocent victim is always compensable. (For example, injuries resulting from horseplay and fights are frequent among enrollees in the Job Corps and Youth Conservation Corps. The confining nature of the employment and long absence from home contribute to this problem. Horseplay is an expected element of the work environment in this case.)

2. Intoxication as a Proximate (Direct) Cause of Injury

Intoxication is limited to whether the fact of intoxication was the proximate or direct cause of death, injury or disease. The fact of the employee's intoxication at the time of his/her death or injury is not necessarily a reason to exclude the claimant from compensation, if it can be shown not to be a proximate cause of injury.

You must have a medical report to prove intoxication. You need to know whether the alcoholic content in the blood ("blood ethanol content") was high enough that the injury was caused directly (or solely) by the claimant's inebriated state, in order for the claim to meet the statutory exclusion.

3. The Employee's Intention to Cause Injury to Himself/Herself or Another

Intent to cause injury to oneself or another is limited to deliberate and intentional acts.

E. Causal relationship

Determining causal relationship between a traumatic injury, disease or death and an individual's work can be very complex. The "burden of proof" is always on the claimant to the extent that evidence must be provided to establish "causal relationship". There are four ways by which an injury or disease can be causally related to an employment situation, resulting in compensation. These are if the disease or injury is:

(a) directly ("proximately") caused
(b) precipitated
(c) accelerated, or
(d) aggravated

by an employment situation.

"Proximity caused", as used in worker's compensation usually is some condition of employment which, in a natural and continuous sequence, produces a disability. For example, a person who slips and falls and receives a broken arm or leg as a result of the fall, traumatic injury would be considered a direct result of the fall; therefore, it is directly caused.

In an occupational disease, the relationship is not as clear or simple. While a medical report is needed in both instances, in the latter situation because of the difficulty in substantiating this relationship, a detailed medical report clearly delineating the circumstances, would be required.

A precipitated, accelerated or aggravated injury or disease has one basic requirement in common—a pre-existing injury, exposure or disease exists. There need be no unusual or extraordinary conditions or employment to bring about an injury or disease. For example, work does not produce organic heart disease, but it can be proved to be a major contributing factor in "precipitation" a cardiac arrest.

An example of "acceleration" is the acting up of tuberculosis because of injury, exposure and the like. In this case a disease might have remained latent and inactive but for the employment.

Temporary Aggravation

Results in no permanent damage—employee returns to previous physical status.

Claimant is entitled to compensation only for the period of temporary aggravation—Claims Examiner determines ending date by review of sound medical evidence.

Claimant is not entitled to compensation for the underlying (pre-existing) disease.

Permanent Aggravation

Claimant is entitled to compensation for permanent aggravation.

CONSEQUENTIAL INJURY/DISEASE

Consequential injury

Consequential injuries can occur to the same or different member. A case in point would be an initial injury to a member which caused a disabling effect; later that disabling effect resulted in another injury, affecting the same member. The latter injury is the consequential injury. On the other hand, an injury to one member may indirectly affect a different member; (i.e., the uninjured member may become impaired in some way due to an overuse of it in compensating for injured member). For example, a claimant with a knee injury may fall which results in a back injury. The claimant's consequential injury would be a "back injury". Consequential injuries seldom occur on the job; otherwise it would most likely be a new claim.

Consequential disease

Consequential disease is defined in much the same way as a consequential injury. Simply put, it is a disease contracted by an employee that results in another serious disease. For example, a heart patient who takes a long period of time to convalesce, might go into a "depression" (a consequence of the first).

RECURRENCES

Definition

Some injuries received on the job do not completely heal and, as a result, persons with this type of condition have recurrences from the old injuries. In such instance, entitlement to additional compensation for the same injuries may be present. Back injuries are commonly known to result in recurrences. Injuries of this type are often thought to be minor at time of occurence, but later serious complication may develop.

When, after returning to work, an injured employee is again disabled and stops work as a result of an increasing or worsening of original injury or occupational disease, such disability is considered to be a recurrence. In these instances a Form CA–2a is required. If a new incident occurs, the matter should be treated as a new injury and Form CA–1 or 2, etc., submitted accordingly.

The important thing to remember about "recurrences" is that no new injury has occurred, but that the claimant suffers an increase or worsening of the original disability. In this context, time (between the original injury or disease and the recurrence) is not a factor in determining whether the most recently reported injury/disease is a recurrence, as long as no new work factors are involved.

Federal employees are eligible for four basic types of benefits under the provisions of the FECA: medical benefits, disability benefits, death benefits, which include allowable funeral expenses and survivor compensation, and vocational rehabilitation. These benefits apply to any disability (temporary or permanent, partial or total) or death sustained as a result of an employment-related disease, or on-the-job injury.

The FECA is a conventional piece of workers' compensation legislation in that compensation for wage loss is computed as a percentage of the employee's salary. Compensation may not exceed a dollar amount equal to 75 percent of the highest wage step grade GS–15 (currently limited to $50,112.50 under 5 U.S.C. 5308 as of October, 1980). The minimum compensation for total disability may not be less than 75 percent of the lowest wage step of grade GS–2. If, however, the employee's salary is less than the lowest wage step of GS–2, the employee is then compensated at a rate equal to his or her salary. In cases where an employee suffers death as a result of employment, monthly payments for all beneficiaries cannot exceed 75 percent of the highest step of a GS–15. The minimum rate of pay used to compute death compensation is the lowest wage step of GS–2.

1. Medical benefits

The FECA provides compensation for any medical services needed to provide Treatment to counteract or minimize the effects of any condition, disease, or injury judged to be causally related to employment with the Federal government. There is no limit on the monetary amount of medical expenses paid, nor on the length of time for which they are paid as long as the need for medical treatment can be substantiated and related to the injury or disease sustained on the job. Benefits will be paid for first aid, medical treatment, hospitalization, and physican's fees, as well as for any drugs, appliances, or other supplies directed for use by a qualified physician. The employee is entitled to the use of Federal medical facilities and physicians, but may elect to utilize the services of the hospital and physician of his or her choice. One exception to medical care is that OWCP will not pay for any preventative treatment.

2. Disability benefits

Federal employees who suffer disabilities which are causally related to employment and result in wage-loss or loss of earning capacity are eligible for one or more of several types of compensation. Disability benefits are classified on the basis of the nature and extent of disability incurred, and are defined as temporary total, temporary partial, permanent total, or permanent partial. Each of these categories will be discussed in turn.

a. Temporary Total Disability

For those employees who are temporarily totally disabled as a result of an occupational disease of traumatic injury, the Federal Employees' Compensation Act (FECA) as amended provides several types of monetary benefits.

If the injury is traumatic (see definition on pages 5 & 6), the disabled employee is entitled to a continuation of his or her regular pay (COP) for a period not to exceed 45 calendar days. Regular pay for COP and compensation purposes includes the base rate of pay for the employee's step and grade, as well as any premium pays he or she may be entitled to. Overtime pay is excluded by statute. Following the first 45 days, if disability and wage loss continues, the employee may receive compensation. This compensation is paid at 66⅔ percent of the employee's pay rate if he or she has no dependents or spouse living at home. If there is a spouse living at home or if the employee has dependents, compensation is paid at an augmented rate or 75 percent of the pay rate.

(1) Waiting days

If continuing disability beyond the COP period *does not* exceed 14 days, the first three days of this continuing disability are excluded from coverage. These three days are known as "waiting days."

Compensation payments for total disability may continue as long as the disability resulting in wage loss continues. As with medical care, there is neither a total dollar maximum, nor a time limitation on compensation paid for total disability.

b. Permanent Total Disability

Benefits provided to employees who are totally and permanently disabled are identical to those paid to employees who suffer a temporary disability. Permanently disabled employees are eligible for an additional payment of up to $500 per month if they require the services of an attendant on a constant basis.

c. Permanent Partial/Temporary Partial Disability

Employees who are partially disabled either temporarily or permanently, by an illness or injury causally related to employment, shall be compensated at a rate of 66⅔ percent of 75 percent of the actual wage loss or loss of wage-earning capacity, incurred as a result of the disability. Benefits are paid for the duration of the wage or loss of wage-earning capacity.

d. Schedule Awards

In addition to income maintenance benefits such as those described above, the FECA provides for limited term payments in cases where an employee suffers anatomical loss or loss of use of a major member of the body. Benefits under these provisions are calculated in the same manner as those paid for total disabilities (66⅔ percent or 75 percent if the employee has a spouse or dependents), but are paid for a specified period of time which is proportional to the severity of loss. In cases where the employee suffers disfigurement of the face, neck, or head, FECA provides that an employee will be paid an award of compensation not to exceed $3,500. Schedule awards are not payable as an additional benefit. They can be paid even if the employee returns to work. Employees may not, however, receive wage loss compensation and schedule award benefits concurrently for the same injury.

3. Death Benefits

The FECA provides a full range of benefits for the survivors of Federal employees who suffer a job-related death. Widows and windowers of deceased employees are eligible for wage loss compensation equal to 50 percent of the deceased employee's regular pay. If the widow or widower has an eligible child, he or she is eligible for compensation equal to 45 percent of the employee's regular pay, plus an additional 15 percent for each child, to a maximum which shall not exceed 75 percent of the deceased employee's regular pay.

Children who are orphaned by death of Federal employees are eligible for compensation equal to 40 percent of the deceased employee's regular pay for the first child plus 15 percent for each additional child, to a maximum of 75 percent of the employee's regular pay. Compensation may exceed the regular pay if such excess is created by cost-of-living adjustment; however, it may not exceed 75 percent of the highest step of grade GS–15.

If a deceased employee leaves no widow, widower or child, benefits will be paid for the surviving legal dependents of the employee as specified in the Act. Benefits are paid to widows and widowers until death, or remarriage if the beneficiary is under age 60. If a widow or widower under age 60 remarries, a lump-sum payment equal to 24 times the monthly compensation he or she is receiving at the time of remarriage is made.

Orphaned survivors receive benefits until they die, marry, or reach the age of 18. If a surviving child elects to pursue higher education, on a first time basis (generally 12 semester hours) payment will continue until he or she has completed 4 years of study beyond the high school level, or until he or she is 23 years of age. Payments will in no event extend beyond the semester or enrollment period in which the beneficiary reaches the age of 23, or completes his/her fourth year of higher education, whichever occurs first. Payment for funeral expenses are also provided to survivors under the provisions of the FECA, not to exceed $800.00. Also, if the employee dies away from his or her home, the cost of transporting the deceased to the place of burial will be paid in full. In addition, a $200 allowance will be paid in consideration of the expense of terminating the Federal employment status of the deceased.

4. Vocational rehabilitation

The FEVA provides for the cost of OWCP-directed vocational rehabilitation necessary to counteract the disabling compensable efforts of any permanent illness or injury causally related to Federal employment. The cost of rehabilita-

tion is paid from the employee's compensation fund and rehabilitation is usually administered through state or private vocational rehabiliation agencies with approval of OWCP. In addition to the cost of rehabilitation, an employee may qualify for a monthly maintenance allowance of up to $200. Vocational rehabilitation benefits are supplemental, and recipients are also entitled to collect total disability compensation payments during the period of their rehabilitation.

A claimant's initial involvement with the vocational rehabilitation, process consists of responding to the rehabilitation specialists initial interview letter. In other words, the rehabilitation process is initiated by OWCP. It need not be begun by the claimant or agency. The specialist uses the information obtained during the interview with the claimant, to assist the claimant in developing the type of program for that individual. If a claimant completes the rehabilitation retraining program, he/she is expected to actively seek employment with the help of the rehabilitation specialist.

Further, since the claimant has been retained, his/her wage-earning capacity for compensation purposes would be based on his/her newly acquired skill, many cases, even if a claimant does not return to work, his/her wage-earning capacity would be high enough so that he/she would no longer be eligible for FECA compensation awarded on the basis of wage-earning capacity.

5. Attendant's Allowance

The FECA provides that an injured employee may be entitled to an additional sum of money if he or she is so disabled as to require a constant attendant. This means injured employee's inability to feed, bathe, dress, get out of bed, or get around without assistance. $500 per month is maximum allowance payable for an attendant in addition to any other compensation awarded. A member of the family may serve as the attendant if it can be shown that the family member had to terminate employment or could not seek employment because he/she had to care for disabled employee.

6 CPI's

Employee's entitled to compensation, and whose first date of compensable disability is one year or more from the effective date of the cost-of-living increase are eligible for same. These increases are awarded when the Consumer Price Index during a three month period (consecutive months), at least a total of three percent over the price index for the most recent base month.

7. Third Party

The FECA provides that where an employee's injury was caused by a person other than the United States, a third party liability exists. If the employee receives compensation benefits under the FECA and also receives a settlement or court verdict from the third party, FECA compensation benefits paid must then be refunded to the United States by the employee.

III. CONTINUATION OF PAY-COP

One of the most significant changes to the FECA program that the 1974 Amendments brought into being was the concept of continuation of pay. Simply defined, Continuation of pay (COP) is the continuation of an employee's regular pay by the employing agency with no charge to sick or annual leave. It is only given in traumatic injury cases and is given for a maximum of 45 calendar days. In order to qualify for COP, the employee must file a written notice of injury on a form approved by the Secretary of Labor within 30 days of the date of injury.

It is essential to understand the concept of COP and determine (1) dates of eligibility, (beginning and ending dates) (2) how to county days of COP when there is intermittent time loss.

1. Dates of eligibility

In determining dates of eligibility, it is essential to know that the first day of COP is either the day following the date of injury (DOI) when there is immediate time loss or in cases where there is no immediate time loss, the first time loss following the (DOI) which is due to the injury.

Additionally, the regulations states that the first day of COP must be taken within 6 months from the DOI. Therefore if an employee was injured on January 10th, the last day on which the employee would be eligible to begin COP would be July 10th. Otherwise, the employee would be eligible to take COP (NOTE: This does not mean that the employee loses eligibility for compensation, but rather just COP entitlement).

Once the employee has begun taking COP, he/she is entitled to a maximum of 45 calendar days of COP. However, they need not be successive days. For example, an employee is injured on May 1st, files a claim on May 2nd. and is off work from May 1st thru May 10th, returning to work on May 11th. The first day of COP would be May 2, and he/she would have used 9 days of COP. The employee would still be entitled to 36 days of COP if he/she incurs additional time loss because of the injury which is certified by the treating physician. The balance of the COP entitlement (in this case- 36 days) may be used only if the recurrence of disability occurs within a 6 month period starting from the first return to duty, following the injury.

If the same employee received follow-up medical care on May 15th, the employee could claim COP entitlement for that day and successive days of time loss which the physician stated were due to the original injury. The same would apply for a recurrence of traumatic injury as mentioned above. In this case since the employee's date of return to work was May 11th, the last day that this employee would be eligible to begin COP would be November 11th. Starting with November 12th, the employee would have to file a compensation claim for time loss. If any of the 45 COP days were remaining as of November 12th, and the employee had not begun another period of disability he/she would lose entitlement to them.

2. Counting COP

In counting COP days, one must use calendar days not work days. This includes holidays and weekends (or days off). When the time loss is intermittent, two things are important to remember, (1) only days are counted (e.g., if one hour is used to see a physician and seven hours are worked, it is still counted as one day of COP and (2) the time loss must be certified by a physician as being a result of the job-related injury. An example of the second element would be when a physician releases an employee on Friday, February 10th. If the employee did not return to work until Wednesday, February 15th, you could not count February 11th thru 14th as COP days, but rather as sick, annual or LWOP time depending on the circumstances. Alternatively, the date of the last visit to the doctor might be Friday, February 10th, but the doctor states the employee is not fit for duty until February 15th. In this case, February 11th thru 14th would be counted as COP days. In the case of a follow-up visit that occurs on a Friday, the employee who returns to work on Monday is charged only one day of COP (Friday).

Note: In rare instances, an employee may have claims in for two separate injuries COP is calculated for each injury and may be overlapping. One COP period is *not* added to another.

3. Controversion of COP

The Form CA–1 indicates that the official superior of the injured employee has the right to "controvert" COP. There is a great deal of misunderstanding and controversion.

Controversion is the option of the employee's supervisor to oppose COP, generally on the basis of at least one of the nine (9) categories specified in the Federal Regulations. It is important to note that the supervisor may only *oppose* COP; OWCP makes the final determination for eligibility for COP. The OWCP office will generally not accept reasons for Controversions other than the 9 given in the Federal Regulations (these are listed in the instructions attached to the CA–1 form). Some of the more common questionable reasons given by supervisors for controversion are: 1) The injury was not witnessed; 2) the employee was careless; and 3) the employee is a "bad" employee and should not be given any benefits. All of these would be highly questionable and OWCP would more than likely deny the agency controversion.

Termination of COP:

The agency may terminate or not begin COP only if the controversion is clearly based on one of the 9 acceptable categories. It should be remembered that OWCP makes all final determinations and can overturn the agency controversion and require that COP be paid.

The 9 acceptable categories for controversion are listed below with an explanation following each:

1. "Disability results from an occupational disease or illness"—If the claim falls into the category of an "occupational disease" the claimant should not be filing a CA–1 for traumatic injury. The CA–2 would be given to the employee with appropriate explanation.

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2. "The employee is excluded by 5 USC 8101(1) B or E"—This section of the law deals mostly with volunteers (unpaid) to the Federal government (e.g., V.A. Hospitals who are in general, not considered civil employees of the U.S. Government for COP purposes. There are some exceptions to this. These exceptions are determined by OWCP and not the agency. In any case a volunteer is not eligible for COP.

3. "The employee is neither a citizen nor a resident of the United States or Canada"—It is important to recognize that if the employee is a citizen, regardless of where he/she is stationed, all compensation benefits (including COP eligibility) apply.

4. "The injury occurred off the employing agency's premises and the employee was not involved in official "off premises duties"—Several factors should be considered here. Agency premises include parking lots and grounds belonging to the agency. When an employee is assigned to go "off premises", the employee is covered from the time he/she leaves his/her official duty station. For example, if an employee is directed to take a training program (including those which involve travel and stay overnight), the employee would be covered from the time he/she left the agency's premises on the first day of travel (his/her home if he/she was not required to report to the agency prior to leaving). The coverage would extend until the employee returned home or to his/her official work station (whichever comes first). This coverage includes evening hours and weekends when employees are on official travel. Another common concern is when agencies sponsor athletic events. Special consideration by OWCP is given to such events and some events are indeed covered for all compensation benefits.

5. "The injury was caused by the employee's willful misconduct, intent to bring about injury or death of self or another person, or was proximately caused by employee's intoxication"—This reason is probably the most common given by supervisors to controvert COP but without a doubt, the most difficult to substantiate. Before OWCP will uphold agency controversion, one of the above must be proven. A willful misconduct case example may help to illustrate this point. If an employee is injured because he/she is not wearing required safety apparel, this is not enough to substantiate controversion because of willful misconduct. To substantiate controversion, the supervisor would have to document that the employee had been told repeatedly to wear safety equipment. Intoxication is also difficult to prove. Blood or breath tests are the only guaranteed way to prove intoxication. However, intoxication by itself is not enough. It must be proven that the intoxication was the proximate (direct) cause of the injury.

6. "The injury was not reported on a form approved by the Secretary of Labor within 30 days following the injury"—OWCP requires written notice to the supervisor within 30 days of the date of injury. If item 10 on the CA–1 is within 30 days of the date of injury and the supervisor receives this notice within 30 days, this reason for controversion does not apply.

7. "Work stoppage first occurred 6 months or more following the injury"—This was explained in the COP section.

8. "The employee initially reports the injury after his/her employment has been terminated"—It should be understood that if an injury is reported prior to separation this exclusion does not apply. At times the employee and/or supervisor knows of an impending termination when an injury occurs. This does not affect any compensation benefits. An employee can be terminated while receiving COP and COP continues until the full 45 days has passed, or medical evidence on longer supports disability, or the agency is notified by OWCP to terminate COP.

9. "The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Job Corps, Work Study Programs or other similar groups"—This only means that persons in this category are not entitled to COP; they are entitled to compensation.

III. FORMS REVIEW

The purpose of this section of the course is to assist you in the basic process of reviewing claim forms. Therefore, we have provided each of you with a copy Pamphet CA–136, which discusses all of the major claim forms by number, title, purpose and individual responsible for the preparation of same.

For contact representatives a special section has been added with emphasis on forms that are most often involved with regard to queries.

A. Form CA–1

Focus Items—8, 9, 10, 11, 16, 24, 27, 31, 32, 33, 35, 36, 37 and 42

Item 8—Indicates place where injury occurred which allows you to determine whether it was on or off premises.

Item 9—Indicates date and time when injury alledgedly occurred.

Item 10—Date of notice was it reported immediately? Determines whether or not injured employee would be entitled to continuation of pay (COP).

Item 11—Shows whether employee has a spouse and/or dependents. This information would be used to determine what compensation rate is used (⅔ or ¾).

Item 16—Indicates whether employee elects leave or COP.

Item 24—Indicates employee's regular work hours and allows you to determine whether injury occurred during regular hours.

Item 27—This item should be the same as item 9.

Item 31—Indicates date employee began using COP.

Item 32—Gives pay rate at the time employee stopped work.

Item 33—Indicates whether or not employee has returned to work.

Item 35—Indicates whether employee was in performance of duty at time of injury.

Item 36—Indicates whether supervisor feels that employee's injury was caused by one of the statutory exclusions. If this block is checked "yes", a detailed explanation should be attached.

Item 37—Indicates if injury was caused by a person other than the United States. If this block is checked "yes", the chief of claims should be notified.

Item 42—Indicates employing agency's decision with regard to continuation of pay (controvert or non controvert) and reasons for same.

B. Form CA–2

Focus Items—12, 13, 15, 29 and 35

Discussion of these items:

Item 12—Date claimant first became aware of disease or illness—time begins on the last date of exposure to an employment hazard or when employee is aware—or should reasonably have been aware of a possible causal relationship between the conditions of employment and the disease.

Item 13—Date claimant first realized disease or illness was caused or aggravated by employment. Time begins to run from either the last date of exposure to the factors of employment which could have caused or aggravated the condition; or from the dates the person was aware—or should have been aware of the relationship between the disability and factors of employment, whichever is later.

Item 15—This block denotes the nature of the disease or illness. It is not necessary that the employee completes this block in precise medical terms. The description however, should indicate the general nature of the condition and part(s) of the body affected. A careful review of this block together with block #13, should rule out any possibility of a traumatic injury being claimed as a disease.

Item 29—Date employee first obtained medical care. This informs the examiner when claimant first went to a doctor or health care facility. If claimant immediately went for medical care, this could indicate that individual may have been aware at that time of a possible causal relationship between the disease and employment.

Item 35—Date last exposed to conditions alleged to have caused disease or illness. This date is when claimant was last exposed to work hazards or factors of employment that may have caused the disease.

C. Form CA–2a

Focus Items—8, 9, 10, 11, 12, 14 and 19

Items 8 & 9—Date of original injury and date of recurrence. These items are used to determine time span between original injury and date of recurrence.

Item 10—Date stopped work.

Item 11—Day and Hour pay stopped—This item lets you know if claimant is in a leave without pay status. If so, claimant will most likely be concerned about compensation.

Item 12—Pay Rate in effect—This item is used in determining whether a recurrent pay rate is applicable for compensation purposes.

Item 14—Date and Hour returned to work—This indicates when claimant returned to work following recurrence.

Item 19—This item describes the circumstances surrounding the recurrence of disability.

D. Form CA–3

Focus Items—9, 10, 12, 13, 18, 20 and 21

Item 9—Date Hour pay stopped—This item is used to determine if claimant is in pay loss status and if so, the effective date of same.

Item 10—Date and Hour returned to work—This item indicates that employee has returned to duty.

Item 13—Shows inclusive dates of sick or annual leave. May also be an indication that claimant is entitled to buy back leave.

Item 18—Shows period that claimant received continuation of pay.

Items 9, 12, 20 and 21—Indicates if pay rate in claimant's job changes. If it is the same or increases, this is not significant, however, if it decreases claimant may be entitled to compensation for loss-of-wage earning capacity.

E. Forms CA–4 and CA–7

CA–7 will be discussed, items on the CA–4 have similar significance.

Focus Items— 4, 5, 6, 7, 8, 10, 11, 12, 13 19 25 27 30 31 and 33

Item 4—Denotes claim for payment or loss of wage.

Item 5—If yes, claimant should obtain a medical evaluation if not already in case file.

Item 6—If yes is checked, claimant not entitled to receive compensation for the period he/she used leave but may request leave repurchase. If no is checked, may be entitled to compensation if proper medical evidence is in file.

Item 8—If "yes" block has been checked, Supervisory Claims examiner should be notified as it may have a bearing on compensation payments.

Items 10, 11 and 12—If answers to these items are yes it could indicate dual benefits—VA, CSC annuity.

Item 13—If there are dependents, claimant's compensation rate is ¾. If no dependents, compensation rate is ⅔.

Item 19—Pay information given for: Date of Injury and Date Employee stopped work (date disability began). These may often be the same date. Claimant entitled to higher of two rates.

Item 25—If claimant used leave, not eligible for compensation, but may repurchase leave. If claimant did not use leave, eligible for compensation.

Item 27—Advises inclusive period of continuation of pay.

Item 30—Date and hour all pay terminated—provides you with information in order to determine when claimant's entitlement to compensation begins.

Item 31—Period for which compensation is claimed. FECA pays only for period claimed.

Item 33—If claimant has returned to work, this may be an indication that final compensation payment has been received. If claimant has not returned to duty, may need form CA–8.

F. Form CA–8

Focus Items—6, 12, 13 and 16

Item 6—This item should be cross checked with the last CA–7 or CA–4 for duplication.

Items 12 & 13—As previously discussed, depending on responses to these items, dual benefits may be an issue.

Item 16—Response to this item allows you to determine last date of claimant's entitlement to compensation.

G. Form CA–16

This form is used to authorize initial medical treatment in *traumatic injury* cases. Special care must be exercised in the issuance of his form since this "authorization" guarantees initial payment of medical bills as outlined on the form, by the OWCP office.

The front of Form CA–16, must be completed by the employee's official supervisor; therefore, if an employee walks into an OWCP District office requesting a form CA–16, he/she should be referred to his/her employing agency for issuance of that form. This allows the agency to be aware of what is taking place.

H. Form CA–17

This form can be used by the agency at any time to request information from a physician, particularly with regard to the employee's ability to return to work.

The form describes the physical requirements of the job and allows the physician to indicate what physical limitations the employee has. It is used most often during a period when COP is being granted.

IV. ADJUDICATION PROCESS

A. Five basics

(1) Timely filed;
(2) Civil employee;
(3) Established fact of injury;
(4) Established performance of duty;
(5) Established causal relationship.

An examiner must review the entire file in order to be sure that all of the above-mentioned requirements are met. However keep in mind that acceptance of a case does not necessarily mean claimant is entitled to COP or compensation. If any one is not met, then the claim can be denied for the specific injury/disease.

Type	Accept	Deny
Traumatic injury or occupational disease	If 5 basic requirements are met: (1) timely filed, (2) civil employee, (3) established fact of injury, (4) established performance of duty, (5) established causal relationship.	If any one of the 5 basic requirements is not met.

B. Period of disability

This is the period of time during which, the employee is disabled (partial or total) due to the work injury or conditions of Federal employment. This period to be compensable, must be supported by medical evidence.

C. Daily roll and automatic roll

The daily and automatic rolls are the two ways by which claimants are most frequently paid compensation. The claimant who has an approved case or claim may wonder why it is necessary to continue to file CA–8 forms every two weeks. If there is no medical evidence to support that a disability will last more than three months, compensation will be paid on the "daily roll" and CA–8's must continue to be filed. In determining the amount of compensation payable, the normal work week of the claimant must be ascertained. If the normal work week is fixed as to days and hours worked, the compensation is then based on the number of work days in which there was wage loss. If the normal week is not fixed as to days and hours worked (e.g., rotating shift, intermittent shift, etc.) compensation is then based on the number of calendar days in which wage loss was exhibited. For further clarification, below is a definition of each.

Daily Payroll

System designed to make short-term disability compensation payments. The payroll is made up daily from a list of claimants who have minor disabilities and have sustained wage loss. These claims are submitted at irregular intervals and processed for pay purposes upon receipt. Compensation is paid on the basis of work days or calendar days lost.

Automatic Roll

List of compensation recipients and their respective compensation entitlements which is forwarded to the U.S. Treasury for automatic payment of compensation each 4 weeks (28 calendar days or each month depending on payment schedule). The list is constantly updated on the basis of entitlement. The type of roll a claimant is put on depends upon the nature of the compensation award and the extent of the disability (LWOP, schedule award, LWEC, Death or disfigurement).

D. Buy-back procedures

One of the most difficult aspects of the compensation claims process to explain is the "buying back" of sick or annual leave. In order to be eligible to buy-back leave the claim must have been filed with OWCP and approval on claim by OWCP must be determined (adjudicated) before this process can begin. There is no time limitation for buy-back provisions, except that the claim must be "timely filed" (within 3 years of DOI) to OWCP.

For example, a person who claims to have been injured at work in December 1972 but who had not filed a claim with OWCP, would not be eligible to buy-back leave used. However, if today is June 1, 1978, and the employee claims to have been injured on June 1, 1976, but has not filed a claim with OWCP, he/she may be eligible for buy-back provision if he/she files claim with OWCP prior to June 2, 1979 and the claim is approved by OWCP.

The buy-back provision if he/she files claim with OWCP prior to June 2, 1979 and the claim is approved by OWCP.

The buy-back provisions were intended to assist the employee who can not afford to be without a regular salary check while the claim is being adjudicated. Leave is bought back from the agency and compensation is not paid to the employee in addition to his/her leave pay. For this reason it is helpful to know the procedure one goes through to have leave reinstated.

The system works as follows:

(1) The employee uses sick or annual leave during the time period while he/she is off work due to a job-related injury (disease). This is charged to the employee's time and leave records.

(2) The employee files for compensation and the claim is approved by OWCP.

(3) The employee requests a statement of leave and money granted from the employing agency payroll office. (see sample memo, authorization and certification)

(4) The payroll office provides the statistics and changes the employee records to reflect a leave without pay status.

(5) The employee's authorization to reimburse the agency and the payroll certification are sent to the Department of Labor, OWCP office.

(6) The OWCP office reimburses the agency for leave used based on compensation entitlement (with the employee receiving or paying the difference).

It is important to understand that when the payroll office supplies the amount of money paid to the employee for leave, it is usually given in a "net" amount. During the time when the employee has received his/her regular check (using sick or annual leave), all deductions were taken from this amount. These deductions include payroll allotments to credit unions, Savings Bonds and United Givers Fund Contributions, etc. When the reimbursement check comes from Labor to the Agency Finance Office, it will not include reimbursement for these deductions. Therefore, it is up to the employee to reimburse the amount to the agency.

There are three other points that need to be covered with an employee when discussing leave buy-back provisions. First, if the period of disability during which leave was taken is less than 14 days (in COP cases less than 14 days following the 45 day COP period), the first three days of leave may not be considered. This is because they are considered "waiting days" and are excluded from compensation entitlement.

U.S. DEPARTMENT OF LABOR,
EMPLOYMENT STANDARDS ADMINISTRATION,
Washington, D.C.

To Finance and accounting.
From Employee's name/organization.
Subject "Buy-back of leave plan.

I wish to use the "Buy-Back" plan to have (type of leave) used from (date) to (date) (Numbers of Hours—Numbers of Days) recredited to my account and charged to Leave Without Pay in order to file a claim for compensation with the Office of Workers' Compensation Programs (OWCP).

Please address a certification to the Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, D.C., and include the following:

(a) Dates and hours of leave
(b) Amount paid to the employee
(c) Statement that records have been charged to reflect sick leave without pay charged in lieu thereof.

Attached is a copy of my authorization to the Department of Labor to reimburse the Finance and Accounting Officer for the above leave.

Please return the certification to the agency compensation office which will forward it with my signed authorization to the OWCP office.

EMPLOYEES' SIGNATURE.

Reimbursement Authorization to CWCP

OFFICE OF WORKERS' COMPENSATION PROGRAMS,
U.S. Department of Labor.

I hereby authorize the Office of Workers' Compensation Programs, U.S. Department of Labor to reimburse the Finance and Acscounting Office, (Name of Agency) (Address of Agency) (amount owed), the sum I was paid for sick leave from (date) to (date).

The sick leave will be recredited to my account and the absence will be charged to Leave Without Pay.

EMPLOYEE'S NAME.

Certification from Finance and Accounting

To Employee's name.
From (Finance and accounting).
Subject Statement to Office of Workers' Compensation Program, Department of Labor.

1. Sick Leave (Amount of Leave) for period covering (date) to (date).
2. Net amount for (Amount of Leave) base pay: (Amount Owed).
3. Records have been changed to reflect (Number of Hours) Leave Without Pay in anticipation of receipt of amount in Item 2.

MARIE B. LAMBERT,
Authorized Certifying Officer.

E. CA–800

This form, if completed properly, provides you with pertinent information contained in a case file. It can be used as a quick reference for responding to telephone calls or it may be used by Contack Representatives in answering question to claimants that come into their offices.

(1) Items 1–19—provide you with background information on the claimant.
(2) Item 20—If claim has been approved it should show examiner's initials.
(3) Item 21—Date claim was approved.
(4) Item 22—Accepted condition(s).
(5) Item 23—Any other disabilities or conditions that are not related to the injury.
(6) Item 24—If claim was informally denied, reason should be given, examiner's initials and date informal denial letter was released.
(7) Items 27–32—If case was formally denied, date of compensation order, reason for denial and examiner's initials.
(8) Items 33–35—If claimant requested a hearing, a date hearing was held, action taken by hearing examiner and date.
(9) Items 36–41—If claimant requested a review/reconsideration of the decision, date review was held, action taken by examiner and date.
(10) Items 42–49—If claimant appeals decision and case goes to the Employees' Compensation Appeals Board (ECAB), date claimant filed appeal, ECAB Docket No., decision issued by ECAB and date of decision.
(11) Items 50–51—If claimant has filed for benefits with the Civil Service or Veterans Administration, claim numbers shown in these items will be an indication.
(12) Item 52—If claimant has reported a change of address, it should be here and address given in item 4 should be in parenthesis.
(13) Item 53—Any third party action taken in the case, such as, release of forms will show here along with examiner's initials and date.
(14) Item 59—Indicates medical payments made on the claim.
(15) Item 66—Indicates the effective pay rate to be used for computing compensation. Also indicates premium pays to be included in the pay rate, as well as CPI, Mini-Max, Health Benefits and Optional Life Insurance information.
(16) Item 67—Indicates type of entitlement—continuation of pay, temporary total disability and schedule award. Also shown is claimant's work week and indications of whether days worked are work days (WD) or calendar days (CD).
(17) Item 67(a)—Indicates first date compensation is to be paid.
(18) Item 67(b)—Indicates ending date of compensation.
(19) Item 67(c)—Indicates number of days lost.
(20) Item 67(d)—Total weekly pay rate.

(21) Item 67(e)—Compensation rate—⅔ if claimant has no dependents; ¾ if claimant has dependents.
(22) Item 67(f)—Examiner's initials.
(23) Item 67(g)—Certifying examiner's initials.
(24) Item 67(h)—Gross amount of compensation payable.

F. Quality control review (for periodic roll cases)

There is a Quality Control Unit in each DFEC office. This unit is responsible for:

(1) Closely monitoring all cases on the periodic disability rolls;
(2) Insuring that form Letter CA–1032 is released in a timely fashion;
(3) Maintaining call-up system for reply to form letter CA–1032 and evaluating replies for completeness, and for making necessary adjustments to the compensation being paid;
(4) Undertaking and expedited LWEC determinations. If there is an increase in residuals of the injury, compensation should be promptly adjusted in claimant's favor.
(5) Fully reviewing all cases on periodic roll at least once per year. If the evidence in a case shows the possibility of a change of status of disability in less than one year, the case should be reviewed on a more frequent basis.
(6) Preparing monthly reports to send to the Deputy Associate Director for FEC, showing the number of reductions and/or terminations of compensation and the number of overpayments found as a result of Quality Control reviews, and the dollar amount of savings in terms of reduced or eliminated compensation each four weeks.

G. Loss of wage earning capacity (LWEC)

When an injury results in permanent impairment and this impairment prevents the employee from performing the job held at the time of injury or other work paying comparable wages, the entitlement to compensation is on the basis of the loss of wage-earning capacity (LWEC) resulting from the impairment.

In making a determination for loss of wage-earning capacity, the claims examiner must insure that certain elements are present in the record or case file. These are as follows:

1. Current and competent medical evidence (usually 6 months or less in age), showing that total disability has ceased and the date. This medical evidence must also show the degree of impairment and the work tolerance limitations.

2. Information from the employee and his agency regarding employee's education, prior experience, training description of job held at time of injury and earnings (past and present).

If these elements are present in the case file, the claims examiner will then determine the entitlement to compensation benefits based on either actual earnings or earning capacity.

Actual earnings—If the employee has demonstrated actual earnings, they may be used so long as they reasonably represent the employee's wage-earning capacity. These wages cannot be considered such if they are in the nature of a gratuity, rather than pay for work performed. These wages cannot be considered if they are for work (1) performed in a "sheltered workshop" rather than an open labor market; (2) of a nondescript or casual nature which may be characterized as "odd-lot work"; or (3) was of a seasonal or temporary character.

Wage-earning capacity—If the employee has no actual earnings or the earnings do not reasonably represent his earning capacity, then the determination as to entitlement is made with due regard to several factors. These factors are: Nature of injury, degree of physical impairment, age, vocational background, avocational background, and the availability of suitable employment.

The entitlement to compensation in LWEC cases essentially amounts to two-thirds or three-fourths (if employee has dependents) of the difference between his earnings at the time disability began and his present earning capacity.

This type of case is monitored closely, as are all cases where compensation payments are being made. The claims examiner monitors LWEC cases by the same procedure outlined in section IV (G), "Quality Control", of this course. Particular attention is paid to changes in disability and evidence of rehabilitation, both of which could effect the earning capacity of the employee.

QUESTION No. 6

TRAINING OF OWCP EMPLOYEES

Department of Labor officials testified that an extensive training program had been developed and implemented for claims examiners and that a training program was being developed for bill paying clerks.

a. Identify the number of claims examiners who have attended the training program and the time period that the training program has been utilized.

Response: 623 claims examiners have attended the National training programs (basic and advanced) during the period 1977–1981 (9/81). This is broken down as follows:

Basic Hire.—1977–1978—163; 1979—68; 1980—28; 1981—22.
Advanced.—1977–1978—172; 1979—110; 1980—60; 1981—0.

Of the 315 claims examiners personnel (includes supervisory examiners) on board, 69 have not received one or both of the National training programs (14 have not had the basic course and 55 have not had the advanced course).

b. Identify whether the training is provided by National Office or district office personnel. If district office personnel provided the training, describe the coordination of such training by the National Office.

Response: National training programs (Basic and Advanced) are provided by ESA Training and Development personnel acting as facilitators with district office staff acting as technical resource people. In addition, local in-house training is performed solely by district office personnel in the district office. The National training is conducted through the OWCP National Technical Assistance Section DFEC and the Associate Director's (FEC) office by means of reports on the number of claims examiners trained, the roster of attendees, and the selection of technical resource people. Training is coordinated through the OWCP National Office by directives to the district offices which require them to provide local in-house training, and through the development (currently in progress) of the National in-house training package.

c. When will the bill paying clerk training program be operational?

Response: October 15, 1981.

QUESTION No. 7

PERIODIC ROLL REVIEW

Department of Labor officials have stressed the success of the periodic roll annual review. Testimony was presented which indicated that in the last year and a half, over 90,000 claim files have been reviewed by OWCP employees. If the periodic roll review has been so thorough, can you say why the cases discovered by the Subcommittee staff and by the participants in the Atlanta project failed to be detected by the annual review process?

Response: The cases reviewed by the Senate Subcommittee staff in our New York District Office mainly involved physician billings. A review of these cases disclosed that none of the claimants was on, or had been on, the periodic compensation roll. As such, there would have been no reason for a periodic roll review to have been conducted on those cases.

The Office does realize that tighter controls are needed on all cases, due to the amount of money involved, whether or not the cases are on the periodic roll. Procedures have been drafted and will be issued by the end of FY 1981 that provide for sample reviews to be conducted by quality control units in the district offices. These samplings will be performed on categories of cases such as recently accepted cases (to ensure that the cases were properly accepted), cases receiving compensation on the daily roll, third-party cases, as well as samples of cases on the periodic roll. In addition, periodic samples will be made of bills paid for medical expenses to ensure that the bills being paid are, in fact, the result of the injury or condition for which the case was accepted.

In regard to the periodic roll cases reviewed in the Atlanta region, it is true enough that errors have been made and cases have remained on the periodic roll when they should have been removed or adjusted. The review of the periodic roll has been a slowly evolving process and has been something that the Office has placed great emphasis on in the last few years. Though the review process is not yet totally fool proof in screening out all errors or changes in claimant condi-

tions, the dollar savings that have been realized support that real progress is being made in this area. As stated previously, the savings nationwide resulting from periodic roll reviews for the period January-July 1981, has been approximately $25 million, which on a projected life basis of 16 years per case will result in savings of $360 to $576 million.

New procedures were recently issued on the monitoring and review of periodic roll cases that will make it easier for our district offices to both conduct such reviews and to remove claimants from the roll who refuse to cooperate in providing sufficient information to support their continuation on the roll.

Question No. 8

QUALITY OF DISTRICT OFFICES

Testimony was presented by Department of Labor officials that the New York district office was not among OWCP's "leading performers," in terms of management. Identify which districts are the best and which districts are the worst in terms of claims management.

Response: OWCP uses a number of quantitative and qualitative measures and standards to gauge the performance of the district offices. Among the quantitative performance measures and standards used are the following:

Performance measure	*Standard*
1. Process Traumatic Cases	85 percent within 1.25 months.
2. Process Non-Traumatic Cases	85 percent within 5 months.
3. Pay Compensation	90 percent within 14 days of adjudication.
4. Pay Medical Bills	90 percent within 28 days of receipt.
5. Review Periodic Roll Cases	Number of cases within quarter as specified by annual work plan.

Qualitative measures of performance are based on accountability reviews of each office, conducted on site, which include in-depth analyses of case adjudication processing (e.g., completeness of records, timeliness of follow-up actions, clarify and accuracy of relation between documentary evidence and adjudicatory decision, etc.). Because each of these various measures has no intrinsic value greater or lesser than any other measure, it is not possible to derive a single overall measure that can be used to precisely characterize a best or worst office or to rank order the offices in relation to each other. An office may perform best in one measure but poorly in another. Moreover, the measurement of performance, especially in the quantitative aspects, occurs quarterly during the year and the performance of offices varies from quarter to quarter. Notwithstanding these limitations of overall performance evaluation, the following offices appear as the top-ranked most frequently over time and in the number of performance measures—Kansas City, Chicago and Cleveland, while the following offices—New York, Washington, D.C., and to a lesser extent Philadelphia, appear as the lowest ranked most frequently over time and in the number of performance measures. All other offices fall in the mid-range of performance.

Question No. 9

OWCP PERSONNEL

Department of Labor officials indicated that personnel shortages are partially responsible for poor management practices. Identify, as of July 23, 1981, the number of claims examiners, supervisory claims examiners, bill paying clerks and medical personnel who are authorized and the number who are on board.

Response: As of July 23, 1981, the FECA Program had on board 266 claims examiners, 49 supervisory claims examiners, 95 bill paying clerks and 10 full-time and 7 part-time physicians acting as District Medical Advisors. Each office is authorized an overall personnel ceiling and it is the responsibility of local management to determine the best ratio among job series. Therefore, there is no specific authorization levels for each job series, such as claims examiner.

Question No. 10

IDENTIFICATION OF QUESTIONABLE MEDICAL PROVIDER PRACTICES

Department of Labor officials testified that an ADP system was being developed to identify patterns of questionable practices. Such a system is to be in effect by October 1, 1981. Please provide additional details regarding this system.

Response: In late 1980, the FEC Program, in conjunction with the Office of Inspector General, developed a "Provider Utilization Report" which allows careful analysis of service frequency and charge amounts by provider on a case-by-case basis. While we believe these reports are extremely useful in the evaluation of "suspect"/questionable providers, and were similarly beneficial in the Subcommittee's investigations, there are limitations to the reports in that identification of "suspect" medical service providers must generally derive from some other source. These sources include bill payment and claims examiner identification, complaints, referral by an investigative agency (such as OIG), annual 1099 reports to the IRS, etc.

However, in order to extend our ability to identify "suspect" providers for more careful evaluation and monitoring, a number of additional "surveillance" type reports are being developed by the FEC Program. These reports will identify providers for utilization review according to the following criteria:

(1) Number of claimants serviced is unusually high; or,
(2) Frequency of service provided is unusually high; or,
(3) Charge amounts per bill or per case are unusually high; or,
(4) Services provided unusually extend beyond return to work or termination of compensation.

These reports are now being specified and will be developed, produced, and several of them are expected to be in place during October, 1981. We expect that future modification and enhancement of the reports will be required to increase their usefulness as we gain further experience in the analysis of provider utilization data.

In addition, we are developing other means of identifying questionable medical providers for utilization review. One of these mechanisms is discussed in answer to question 11 below. We are also developing formal mechanisms for identification of providers indicted/convicted for abuse under other Federal/state programs. Finally, we are evaluating identification/utilization review procedures and mechanisms used by other Federal, state, and private health benefit programs for possible use by the FEC Program.

Question No. 11

VERIFICATION OF MEDICAL SERVICES

In February 1981, the Inspector General recommended that OWCP provide FECA claimants with a statement which would set forth all medical services which had been paid under their claim, and would require the claimant to verify these services with OWCP. This would alert the claimant and the Department of Labor to any false billings by the medical service provider. Department of Labor officials testified that such a system would be implemented soon. Please set forth details of OWCP's plans to implement this program and state when this system will go into effect.

Response: The FEC Program is currently developing a mechanism for reporting all payment transactions to appropriate parties with a requirement for verification. For example, all direct payments to medical service providers will be reported to the beneficiary to whom the services were provided with a requirement that the beneficiary report if the service was not provided or if the service was otherwise paid. These payment reports will cover all compensation and medical service (direct or reimbursement) payments and will be directed to the claimant, the employing agency, and, where appropriate, the medical service provider.

It is currently expected that this payment transaction reporting system will be implemented by the end of calendar 1981.

QUESTION No. 12

OWCP ACCEPTANCE OF PHOTOCOPIES

Department of Labor officials informed the Office of Inspector General in October, 1980, that procedures were being revised to preclude the acceptance of the photocopies of medical bills. Please describe when such procedures will be developed and when they will be implemented. If photocopies are still being accepted, please justify and identify those district offices which are accepting photocopies.

Response: Our Federal (FECA) Procedure Manual (revised January, 1981) requires that only original itemized bills be processed; photocopied bills may only be processed if they contain an original provider signature. These procedures are being reemphasized in a Program directory to be released to all FEC district offices.

QUESTION No. 13

EMPLOYER IDENTIFICATION NUMBER (EIN) VERIFICATION

Department of Labor officials testified that present discussions with the Internal Revenue Service (IRS) has not resulted in a satisfactory resolution regarding verification of medical provider EINs. If the Department of Labor cannot resolve this problem promptly, what plans have been considered to utilize a different identifier, other than the EIN? What offices at IRS have been contacted regarding this problem and what was the date of the most recent contact. Please provide copies of all correspondence between the Department of Labor and the Internal Revenue Service regarding this matter.

Response: On several occasions since January, 1981, FEC National and Regional office staff have been in contact with IRS National and Regional officials to determine available means for verification of provider EINs. To date these contacts have been telephonic, the most recent being in mid-July, 1981. On each occasion, we have been informed by IRS that no current capability exists, or is being developed, which allows cross-referencing of EIN to provider name or even verification that a specific EIN has been assigned to a bona fide medical service provider or that it is the only EIN so assigned.

Since EINs are used for tax reporting purposes, including our 1099 reporting requirement, it is considered essential that we continue to use EIN as the primary identifier of medical service providers. The Office of Workers' Compensation Programs is contacting appropriate IRS officials to explain problems encountered with EIN verification and we will be working closely with the IRS in developing a means for satisfactorily addressing these problems.

QUESTION No. 14

BILL REJECTION BY NEW YORK DISTRICT OFFICE

Department of Labor officials testified that the New York office had rejected 13,000 bills totaling over $1 million. Please provide additional information regarding these bill rejections.

Response: The FEC Program currently monitors the number of bills processed for payment that are rejected as a result of computer edits for potential duplicates. These bills have already been adjudicated and, once rejected, are researched and may ultimately be reprocessed for payment if they prove to be legitimate unpaid bills.

There were 13,069 bills entered into the ADP system by New York between October, 1980 and June, 1981 which were rejected by the automated bill pay system. These rejections totalled $1,047,076.01.

All bills are not paid routinely by the system. Those bills rejected were those failing the duplicate checks, and bills submitted for period of service for which payment had already been made. These rejected bills would have to be researched and validated by New York before payment could be made through the system.

X. LETTER FROM DR. JOSEPHS ATTORNEY

MINEOLA, *N.Y., July 21, 1981.*

U.S. SENATE,
Committee on Governmental Affairs, Senate Permanent Subcommittee on Investigations, Washington, D.C.
Attention: S. Cass Weiland, Chief Counsel.

DEAR MR. WEILAND: In response to your letter of July 1, 1981, please be advised that Dr. Allen Josephs would be willing to appear before the Senate Permanent Subcommittee on Investigations concerning a review of fraud and abuse in the Federal compensation claims program. As you know, Dr. Josephs

is currently serving a sentence as a result of his conviction for filing false claims with Blue Cross/Blue Shield during the period 1975–1977. I have been advised, however, by Howard Cox, an attorney on your staff, that the Committee has reason to believe that there were false bills submitted by Dr. Josephs in connection with certain Federal workmen's compensation claims, and that it is the intention of the Committee to refer such evidence to the U.S. Attorney for criminal prosecution purposes.

Under these circumstances, Dr. Josephs would be willing to testify only on condition that your Committee obtain an order of immunity, so that his testimony before the Committee, or leads obtained therefrom, could not be used to criminally prosecute him. Were it not for the fact that we have been advised by counsel that it intends to refer evidence of Dr. Josephs' alleged involvement in the filing of false claims, we would not make such a request. Dr. Josephs emphatically denies preparing or causing to be prepared any false documentation in connection with claims filed for Federal workmen's compensation.

Under these circumstances, we would appreciate being advised whether or not the Committee intends to obtain an immunity order, so that Dr. Josephs can fully and freely testify concerning these matters.

Very truly yours,

JOSEPH W. RYAN, JR.

XI. NEWSSTORIES SUBMITTED FOR THE RECORD BY SENATOR ROTH

41 PERCENT OF PAID U.S. COMPENSATION CLAIMS FOUND INVALID

(By Robert H. Snyder)

WASHINGTON.—A confidential audit by the Labor Department of its own federal workers' compensation program reveals that 41 percent of disability claims paid were invalid and should never have been approved.

An examination of 285 disability and death claims, a relatively small sample, uncovered more than $3.28 million in improper payments.

Workers' compensation insurance "is becoming a retirement program" for a growing number of federal workers, the auditors concluded. The program covers 3.25 million civilian federal workers and now pays out about $700 million a year in compensation.

The audit cited case after case of apparently illegal or highly questionable payments and pointed out that there is very little policing of the program.

The audit report, dated October 20, 1977, is the only Labor Department audit ever done on the program, which is operated by the department's Office of Workers' Compensation Programs. There appears to have been little, if any, corrective action taken against specific cases cited in the report.

When the auditors checked 202 claimants against Social Security reports, they found that 43 (21 percent) of those who had been ruled totally disabled were still working.

John H. Mumford, deputy assistant secretary of labor in charge of the program, said yesterday it is illegal to be working while listed as totally disabled.

But Mumford said the suspected fraud cases were never referred to the Justice Department for prosecution. He and a Labor Department lawyer said that under the Privacy Act the Social Security Administration could not release the names of the 43 claimants to the Labor Department. Furthermore, Mumford and the lawyer argued that the Privacy Act and the Tax Reform Act of 1976 would prevent the Justice Department from getting access to the records.

However, the Justice Department disputed this. Richard W. Beckler, deputy chief of the Justice Department's fraud section, said as a general rule the department can obtain tax or Social Security records as part of any criminal fraud investigation.

Not only did Labor Department officials never refer the case for prosecution, but the same officials refused to release the audit report to the public.

A copy of the audit was obtained from the office of Rep. Donald J. Pease, D–13, of Oberlin. Pease has introduced legislation to reform parts of the compensation law.

Told yesterday that the 43 cases were never referred for prosecution, Pease said he would immediately send the report to the Justice Department, requesting an investigation. Pease also said he would write to the Labor Department asking why no action was taken on the matter.

In addition, Pease said he has become alarmed over all the problems in the federal program and has requested a new investigation of the workers' compensa-

tion office by the General Accounting Office, the investigative arm of Congress.

Mumford defended the compensation program yesterday and questioned aspects of the department's audit. He said he originally requested the audit be conducted when he chaired a task force to review operations of the workers' compensation office.

Mumford acknowledged that the system has some serious problems but he stressed that major improvements have been made over the past 18 months.

One striking case in the audit involved a military reservist who committed suicide while on active duty in Japan. His family has received more than $50,000 in benefits and continues to receive $4,000 asnually, according to the audit. But the auditors pointed to a specific section of the federal law prohibiting payment of death benefits in a suicide case.

Mumford said the death took place 25 years ago. He said he did not know if payments were continuing today. He disputed the auditors' interpretation of the law and said in his judgement the payments were lawful.

One of the areas heavily criticized by the auditors was the obtaining of compensation for injuries not caused by federal employment, but aggravated by federal employment.

The auditors said in 70 cases (25 percent) "OWCP has awarded compensation for physical and mental disabilities which were aggravated by work-related factors but were not caused by same. In some cases aggravation could be attributed to the normal aging process."

The auditors cautioned: ". . . If the department continues to award full compensation for aggravation of conditions arising from normal body deterioration, it is conceivable that every federal employe could end up on the Federal Employment Compensation Act (FECA) disability or death rolls."

Mumford also took issue with the findings of the auditors on this point. He said aggravation of a pre-existing injury is compensable under federal law.

The audit noted that "FECA is becoming a retirement program." Of the 285 claims checked, 25 claimants were 65 or older. Eleven were over 70. One was 86.

Auditors recommended that "compensation be limited to those years for which wages are normally earned."

Mumford said present law allows the collecting of compensation by claimants during their natural lives. There has been no move to change this.

Another area criticized by the auditors was the finding that claims were paid out for as long as five years without a new medical review. The auditors said that even though compensation can be suspended over failure to submit current medical reports and other updating documents required, no payments were suspended when violations occurred. In 52 cases reviewed, the proper documentation was not found.

Mumford said presently every claim gets an annual review.

In general, Mumford questioned whether the audit findings are representative of the entire program.

"Be mindful that 285 cases out of about half a million that were active at the time is not a large sample size."

In addition, a preliminary audit report released in April by the General Accounting Office also found that 41 percent of claims spot-checked by GAO were questionable. The GAO reviewed 233 claims in the program.

Pease said: "It seems to me that Labor Department audit is pretty damning . . . there is clearly a problem and it is clearly costing the taxpayers millions of dollars. I think it's quibbling to wonder whether it's 41 percent or 35 percent or whatever. Whatever it is, it needs to be corrected."

[From the Sunday Plain Dealer, June 25, 1978]

The Waste Machine

If President Carter and Congress are looking for examples of government waste and the misuse of tax money, they might want to focus on the Department of Labor's administration of the workers' compensation program for federal employes.

Robert H. Snyder, chief of The Plain Dealer's Washington bureau, has revealed that two government audits found 41 percent of surveyed disability claims paid by the department were invalid and never should have been approved.

The department's survey of a mere 285 disability and death claims turned up $3.28 million in improper payments. The potential waste in a program covering 3.25 million current and former government employes is staggering.

A second audit, also based on a limited survey and conducted by the respected General Accounting Office, arrived at precisely the same figure for the percentage

of invalid or otherwise improper claims paid by the Labor Department—41 percent.

Chapter 2 of this disconcerting tale is that the Labor Department appears quite satisfied to let the dust settle and return to business as usual.

For example, auditors found that 43 of 202 claimants receiving total disability payments were in fact still employed. The receipt of such payments by persons still working violates federal law.

But these cases of possible fraud were never referred to the Justice Department for investigation. The Labor Department believes opening case files to scrutiny would violate the federal privacy act. A Justice Department fraud investigator disagrees. But as far as we know, the Labor Department never even raised the question with officials at Justice.

In fact, the audit itself was withheld from the public and might be a secret today had not the office of Rep. Donald J. Pease, D–13, of Oberlin, provided a copy to Snyder.

The taxpayers are entitled to two general remedies for what we strongly suspect constitutes a significant and wholly unwarranted drain of the federal treasury. First, the Labor Department's Office of Workers' Compensation Programs must institute vastly tighter administrative procedures. Second, the entire program could benefit from new law that would curb waste and correct structural defects in the system.

Pease, who played a major role in cleaning up the mess in Ohio's workers' compensation system during his previous service in the Ohio Senate, has introduced such legislation. It merits the thoughtful attention of the House of Representatives.

In the meantime, we suggest that the potential savings more than justify the cost of an increase in the Labor Department's ridiculously inadequate staff of 20 claims investigators.

A speedup in the department's plans to computerize its compensation records over the next two years is advisable.

In fairness, we must say the Labor Department has made some improvements in administration. But the extent of the problem clearly requires a much, much greater effort.

[From the Plain Dealer, Apr. 14, 1978]

Marshall to Crack Down on Abuses, Corruption

(By Robert H. Snyder)

Washington.—Secretary of Labor F. Ray Marshall yesterday announced a crackdown on "corruption, mismanagement and financial abuses" in his department, including the federal workers' compensation program.

Marshall said he is establishing an office of special investigations in the department with a staff of 200. Marshall said the new office "will have full authority to pursue investigations free from political and bureaucratic pressures."

The two areas of abuse in the department he said he is most concerned about involve the Comprehensive Employment Training Act (CETA) programs and workers' compensation.

Regarding workers' compensation he noted, "It is one of the worst programs that we have . . . It has won an award as one of the worst in the government."

He did not dispute a finding of the General Accounting Office, presented to a congressional panel Wednesday, that 41 percent of claims awards were questionable.

Members of the House subcommittee that heard the GAO's critical report said no legislation is coming this year.

The subcommittee has been considering a bill sponsored by Rep. Donald J. Pease, D–13, Oberlin, that would reform certain aspects of the program.

Marshall vowed to "root out to the full extent of our authority" any problems with CETA abuse.

"I'm absolutely convinced that the CETA-type programs are essential to getting us to full employment and dealing with the problem of inflation as well. But we're not likely to be able to utilize the full potential of CETA if you get cases of fraud and abuse."

Labor Department officials maintain that, considering the size of the CETA program—it currently employs some 750,000 persons in public service jobs—the number of reports of abuse and fraud has been small.

O