

2012

# Physician Review of Workers' Compensation Case Files: Can It Affect Decision Outcomes?

Mark E. Hammett

Christopher Jankosky

John Muller

Elizabeth Hughes  
*Old Dominion University*

Francesca Litow

Follow this and additional works at: [https://digitalcommons.odu.edu/commhealth\\_fac\\_pubs](https://digitalcommons.odu.edu/commhealth_fac_pubs)



Part of the [Internal Medicine Commons](#)

## Repository Citation

Hammett, Mark E.; Jankosky, Christopher; Muller, John; Hughes, Elizabeth; and Litow, Francesca, "Physician Review of Workers' Compensation Case Files: Can It Affect Decision Outcomes?" (2012). *Community & Environmental Health Faculty Publications*. 55. [https://digitalcommons.odu.edu/commhealth\\_fac\\_pubs/55](https://digitalcommons.odu.edu/commhealth_fac_pubs/55)

## Original Publication Citation

Hammett, M. E., Jankosky, C., Muller, J., Hughes, E., & Litow, F. (2012). Physician review of workers' compensation case files: Can it affect decision outcomes? *Military Medicine*, 177(1), 17-22. doi:10.7205/milmed-d-11-00262

## Physician Review of Workers' Compensation Case Files: Can It Affect Decision Outcomes?

*CAPT Mark E. Hammett, MC USN\**; *CAPT Christopher Jankosky, MC USN†*; *John Muller, MD, MPH\**;  
*Elizabeth Hughes, RN, MPH‡*; *Francesca Litow, MD, MPH§*

---

**ABSTRACT** Objective: To identify common attributes of Federal workers' compensation cases referred to Navy physicians for medical opinions and to determine the impact of the review on the final case decision. Methods: Retrospective case study and descriptive analysis of 258 opinion letters written by physicians on referred cases from 2006 to 2010. Results: Navy physician opinions were considered in the outcome in some of the cases, and there was a statistically significant difference between the claim acceptance rate in the study population and the total population. Worker age was correlated with certain claim types. Conclusions: There is preliminary evidence that the opinion letters of Navy physicians influenced case decisions. Because of the selection bias in how the cases came to the study population, a prospective cohort study is warranted to establish whether this conclusion and the other results noted are valid.

---

### INTRODUCTION

The history of Federal workers' compensation legislation goes back to the late 1800s, but the Federal Employees' Compensation Act (FECA) of 1916 is the basis for the current system.<sup>1</sup> The FECA covers all civilian employees of the United States, except those paid from nonappropriated funds. Special legislation provides coverage for a number of other groups outside of the Federal government. All kinds of occupational injuries and diseases are covered by FECA, and the spectrum of medical issues that are presented for payment can be complicated. The Department of Labor's Office of Workers' Compensation Programs (OWCPs) administers the program. The costs of the benefits paid to the employee are charged back to the employing agency. Historically, the US Postal Service has led the list of agencies with the most workers' compensation chargeback, and the combined Services within the Department of Defense always follow in the second spot. The Department of the Navy typically leads all other Services in total chargeback. The total chargeback figure for all Federal claims from July 2008 through June 2009 was \$2.73 billion, and there were 250,673 claims handled during that period. New claims totaled 129,690 of that number.<sup>2</sup> This chargeback figure underestimates the total outlay for workers' compensation, because a provision of the FECA allows an employee

injured on the job to receive up to 45 days of pay and benefits to stay home and recuperate from an injury. This is paid directly from the employing agency, and the Department of Labor does not track that cost.

The increasing cost of medical care, the increase in the number of Federal employees, the aging American workforce, and legislatively defined benefit additions over time have all contributed to a steady increase in the cost of the program.<sup>3,4</sup> The proportion of workers aged 55 years and older is projected by the Bureau of Labor Statistics to increase by nearly 40 million by 2018, an increase of 43%.<sup>5</sup> This will make it the fastest growing segment of the working population. Chronic conditions can be aggravated by occupation and can predispose workers to increased rates of injury.<sup>3</sup> The burden of chronic medical problems seen in the older workers will more than likely have an effect on workers' compensation cost in all areas over time. Correctly identifying chronic conditions masquerading as occupational illness will present a challenge.

In 2000, Naval Sea Systems Command initiated a program to limit the Navy's liability for compensation costs that result from occupational injuries and illnesses occurring at its bases. A cooperative relationship developed between the injury compensation specialists charged with managing this project at the Philadelphia Naval Shipyard and the Occupational and Environmental Medicine (OEM) physician who was staffing the shipyard clinic. In selected cases, the physician reviewed the case file and would sometimes submit a medical opinion letter to the claims examiner. The letter would support or question the claim, based on the medical facts present in the file. OWCP claims processing rules require the claims examiners to consider input from the employing agency's physician, but the agency physician's opinion may not be the sole basis for a case decision.<sup>6</sup> It appeared to the claim managers working in the program that favorable claim decisions resulted in cases where the physician intervened early in the process, and this outcome encouraged the Commander, Naval Installations Command (CNIC) to formalize the procedures

---

\*Occupational and Environmental Medicine Department, Navy and Marine Corps Public Health Center, 620 John Paul Jones Drive, Portsmouth, VA 23708.

†Department of Preventive Medicine and Biometrics, Uniformed Services University of Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814.

‡ODU/EVMS MPH Program, Old Dominion University, Health Sciences Room 3134, 4608 Hampton Boulevard, Norfolk, VA 23529-0288.

§1001 Indian Creek Lane, Wynnewood, PA 19096.

The views expressed in this article are solely those of the authors and do not reflect the official policy or position of the Uniformed Services University of Health Sciences, the U.S. Navy, the Department of Defense, or the U.S. Government.

for examining claims and providing medical input by Navy physicians. Several Navy physicians working at various locations volunteered to provide medical expertise to the claims processors at CNIC, and, when it seemed appropriate, they would insert opinion letters into the claim record early in the claim adjudication process for OWCP to consider. Case tracking began in late 2006, and the descriptive results of that effort are provided here.

Very few Federal agencies have physicians available to provide input into a given workers' compensation claim, but physicians are the only ones, according to Department of Labor claim processing rules, who can argue the issue of the claimant's diagnosis and the relationship of the diagnosis to the claimant's occupation.<sup>7</sup> The purpose of this article is to analyze and quantify the effects of medical review of the workers' compensation claims, to highlight how OEM physicians can assist non-physicians who are tasked with handling complex claims, to encourage other OEM physicians to initiate local program improvements, and to encourage more study of this initiative.

## **METHODS**

We conducted a descriptive epidemiological study on a referred group of 325 workers' compensation cases filed with Navy Injury Compensation Program Administrators (ICPAs) from all over the United States, beginning in August 2006 until September 2010. The cases were forwarded by the ICPAs through the CNIC Workers' Compensation Office, where selected case information was entered into an Excel spreadsheet (Microsoft, Redmond, Washington) for tracking purposes. The physicians had no input as to the type of cases that were sent for review. The CNIC Workers' Compensation Office requested that the ICPAs send cases that had not been adjudicated by the OWCP yet, or when the ICPAs needed medical advice on how to proceed with the claim process. The Workers' Compensation Office kept track of numerous pieces of data about the cases, including: the type of illness claimed on the case, the date that it was sent to Navy physicians for comment, the date that it was returned, the OWCP's case decision, and a calculated dollar figure of cost avoided (if the case decision was a denial of the claim). Correspondence on all the cases was reviewed to determine whether the Navy physicians' reviews influenced the definitive action by the OWCP. Of the 325 possible cases in the database, 40 were excluded or combined. Such exclusions or combinations occurred when multiple claims by the same patient at the same time were grouped into a single case analysis, when the Navy physician simply answered a question for the ICPA on the case and did not write a letter to the OWCP or to the treating physician, or when the Navy physician could not provide any support because of inadequate medical record documentation. Key variables collected on the 285 remaining cases included the following: claimant age, gender, illness/injury claimed, date the case was referred to the Navy physician, date the case

was returned to the ICPA, the claimant's wage grade type, the Navy physician's recommended disposition on the case, and the OWCP's decision on the case. Some of these data fields could not be ascertained in all 285 of the cases.

Descriptive statistics were calculated, and tests of association were performed using Excel (Microsoft) and SPSS version 15.0 (SPSS, Chicago, Illinois). Using the  $\kappa$  statistic, we assessed the level of agreement between the physicians' opinions and the final claim decision of the OWCP in the cases where the decision was known. The two-sided  $z$ -test was employed to compare the proportion of males in the study population to the proportion of male employees in a comparison population that was constructed from two different sources. Since the gender distribution of employees working for the Federal government in the Wage Grade (WG) category of workers is greatly different than those working in the General Services (GS) category in the Federal government, we used the proportions of WG and GS workers in the study population to create a composite comparison population that more closely mirrored the distribution of claimants. We wished to try and determine whether there was a statistically significant difference between the study population's acceptance rate and the Navy-wide acceptance rate for workers' compensation cases. To do this, we used the  $z$ -test again to compare the proportions. Finally, we explored the relationship between the claimant's age and the type of claim, using the one-way analysis of variance (ANOVA) method.

## **RESULTS**

The claimant's age was available in 169 of the 285 cases, and the ages ranged from 24 to 81 years old. Both the average age and the median age of the study subjects were 55. The average turnaround time on the cases sent to the reviewing physicians was 14 days.

Musculoskeletal (MSK) problems were the most common cause of injury and illness (Table I). MSK complaints were subcategorized into regions of the body. Upper body complaints were most frequently a diagnosis of carpal tunnel syndrome, but rotator cuff injuries were also well represented in this group. MSK problems of the spine were most frequently in the low back region, but cervical stenosis and arthritis was also a frequent referral in this grouping. MSK problems of the lower extremities were most frequently knee problems. Hearing loss was the second most common category of claim sent for review. The "central nervous system (CNS)" category contained cases that, with one exception, contained head trauma or chronic headache cases. The one exception was a case of chemically induced leukoencephalopathy. The cases in the "Psychiatric or Mental Health" category were exclusively stress-related cases. The "Respiratory" category contained mostly asbestos lung disease, but it also contained several asthma and allergy cases. The "Other" category contained a mix of cases that included a hernia, a retinal detachment, an orbital fracture, and a deep vein thrombosis.

The reviewing physicians recommended that the claim be accepted in 40.7% of the cases referred (116 of 285). Of the 285 cases analyzed, there were 250 cases where the OWCP decision on the claim was known. The case counts and the percentages of agreement or disagreement are presented by case category in Table II. The physicians and the OWCP agreed on how the claim should be decided 63.2% of the time (158 cases). This resulted in a  $\kappa$  of 0.315 (confidence interval = 0.203–0.428) (Fig. 1). A  $\kappa$  from 0.2 to 0.4 is generally considered “minimal” agreement.<sup>8</sup>

The OWCP's claim acceptance rate on the study population (where the case decision was known) was 72% (180 of 250). The OWCP's claim acceptance rate for all Navy claims in 2009 was 87.5% (5,025 of 5,756). (R. Slighter, unpublished data, Civilian Personnel Management Service [CPMS], Washington, DC) Using the two-sided *z*-test to compare the two proportions, the difference in the acceptance rate between the two populations was significant at the 0.01 level.

Men filed substantially more of the claims than women, i.e., 82.5%. The percentage of males in the comparison population was 78.5%. As mentioned above, the gender distribution in the work force is greatly different in the WG pay grade system than that found in the GS pay grade system. Men com-

prise 90% of the workers found in the WG system. They only comprise 59% of the GS pay grade.<sup>9</sup> The breakdown of the pay grades in the claimant's population we studied found that 63% were in the WG pay system (163 of 259) and 37% were in the GS pay system (96 of 259). We used this proportion and the gender distribution found in the Federal government to derive a percentage of males to compare the claimant population against the comparison population, which was 78.5%. The two-sided *z*-test performed to compare whether there was a significant difference between the male population of claimants and the comparison population of workers showed that there was no significant difference between the two populations, *p* = 0.11.

Using the ANOVA, we tested the hypothesis that there was no association between the claimant's age and the category of case. This hypothesis was rejected (*p* = 0.024). Further investigation showed that the only significant differences were between age and hearing loss claims, CNS claims, and MSK–spine claims. The mean age of the hearing loss claimants, 58.8 years, was the highest. The two categories showing the lowest mean age were MSK/spine (51.7 years) and CNS claims (46.3 years).

**DISCUSSION**

We recognize the selection bias inherent in our study. The Navy ICPAs referred cases in which they noticed something unusual, or which required further clarification from a physician to help support or contest the claim. Given that bias, one might expect that the overwhelming majority of cases would have the Navy physician opposing the claim. This was not the case. In this study, the Navy physicians recommended a case decision in favor of the claimant in almost 41% of the referred cases. The majority of those cases involved hearing loss, and the reasons for that are fairly straightforward. First, workers are not routinely removed from work because of documented hearing loss. Most workers are still capable of doing the job, even though their hearing acuity is declining over time. The worker is generally informed of the hearing loss, and he or she is counseled on hearing conservation measures that must be employed to limit further damage. Supervisors

**TABLE I.** Case Counts and Percentages by Type/Mean Age by Case Category

	Cases	% of Total		Mean Age (Years)	
		Cases	Males		Females
Cancer	4	1.4	4	0	56.2
CNS	6	2.1	6	0	46.3
Dermatology	2	0.7	1	1	54.5
Hearing Loss	98	34.4	97	1	58.8
Psychiatric or Mental Health	7	2.5	4	3	53.0
MSK, Upper	47	16.5	33	14	55.8
MSK, Lower	42	14.7	28	14	51.8
MSK, Spine	45	15.8	36	9	53.4
Respiratory System	28	9.8	21	7	55.5
Other	6	2.1	5	1	55.0
Total	285	100	235	50	54.7

**TABLE II.** Agreement Between Physicians and OWCP by Case Category

	MD “Accept” & OWCP “Accept”	MD “Deny” & OWCP “Deny”	MD “Accept” & OWCP “Deny”	MD “Deny” & OWCP “Accept”	Totals
Cancer	1	2	0	0	3
CNS	2	3	0	0	5
Hearing Loss	60	7	7	20	94
Psychiatric or Mental Health	1	5	0	2	8
MSK, Upper	10	8	1	20	39
MSK, Lower	7	14	0	15	36
MSK, Spine	8	12	0	17	37
Respiratory System	6	10	0	9	25
Other	1	1	0	1	3
Total	96	62	8	84	250
Percent	38.4	24.8	3.2	33.6	

		OWCP		
		A	D	
Physicians	A	96	8	104
	D	84	62	146
		180	70	250

Number of observed agreements: 158 (63.2%)  
 Number of agreements expected by chance: 115.8 (46.3%)  
 Kappa = 0.315 (CI = 0.203 to 0.426)

**FIGURE 1.** Agreement between Navy physicians and OWCP.

are instructed to enforce hearing protection guidelines on the job. The Navy has a threshold of hearing acuity, below which the worker must be screened by an audiologist, otolaryngologist, or OEM physician for fitness for duty. In practice, the worker is generally not removed from the workplace when he exceeds that threshold. Second, many workers come to work for the Federal government with pre-existing hearing loss. When the Department of Labor is considering payment of scheduled awards for hearing loss, the government must pay for this prior loss under the FECA. This precedent has been frequently affirmed by rulings of the Employee Compensation Appeals Board (ECAB). The ECAB references other case law precedents described by Larson.<sup>10,11</sup> The principle can be paraphrased as "the Government must take the employee as it gets them."<sup>12</sup> The Navy physicians providing the opinions generally understood this concept and made no attempt to apportion the prior loss, knowing that the case would be accepted for full payment.

To compare the Navy physician recommendation to the actual case decision, it was necessary to create a binary result, i.e., the case should either be "accepted" or "denied." However, this oversimplified many of the nuanced arguments that the Navy physicians made. In some instances, the physician recommendation was classified as "denied," but the physician's recommendation really addressed those issues specific to medical management, fitness for duty, or return to work in a light duty status. This physician input often included recommendations that were implemented at the level of the claimant's health care provider, and it indirectly resulted in a claimant returning to work. Thus, the binary nature of the physician opinion classification may have overstated the non-concurrence rate between the physician and the Department of Labor.

An item of interest is the difference in the ages of the claimants, as made evident by the ANOVA test. The mean age of the hearing loss claimant was the category of claim that made the most impact because of the size of the claim numbers and the difference in the mean age. One reason for the older population of claimant may be that the claimants wait to file for compensation in the last year or two before retire-

ment. An alternative reason could be that there is some point in the continuum of hearing loss where the claimant reaches a level of disability that he files for benefits. Both explanations seem plausible, and it is not obvious which is the more likely, or if there is another explanation. The greatest absolute difference in category age vs. the population mean is seen in CNS claims. Although there are only six claims, the absolute difference between the CNS mean age and the study mean age is nine years. Looking at the individual cases, this makes sense. Most of the CNS cases were associated with head trauma in workers due to falls, and the cohort's average age was skewed by two young firefighters who sustained head trauma performing emergency service.

Many Navy physicians' letters illuminated facts from the medical records that supported non-occupational causes of injury or illness, contradicting the claimant's personal physician. As an example, numerous claims were made by employees who experienced pain while doing routine activity at work, such as knee pain when standing up from a chair. A visit to the doctor demonstrated osteoarthritis and tears in a meniscus of the painful knee. The treating physician would support the claim that the meniscal tears were occupationally related, and that should result in all workers' compensation benefits for surgical repair and rehabilitation of the joint, time off from work for recuperation and rehabilitation, and all future problems with the specific joint injured at work. This *post hoc, ergo propter hoc* argument has not been supported by the case decisions of the ECAB, but the claims are frequently accepted without debate by some claims examiners.<sup>13</sup> In these types of situations, the Navy physician could intercede with information that pointed the claims examiner to medical literature showing where certain meniscal tears were most frequently associated to the claimant's osteoarthritis, and that there was no convincing history pointing to a work event to substantiate that the condition was occupationally related. There were many complex cases where the Navy physicians' information proved critical in framing the decision to include other, non-occupational, causes for a claimant's injury/illness.

The efficacy of the physician reviews is an important issue. The position of some within the Department of Labor and the CPMS of the Department of Defense was that the OWCP may not even consider the Navy physician's letter when making their decision. This notion was disproven early in the course of the project. Case and appeal decision letters obtained from the ICPAs frequently used the exact words from the physician's letters in the Statement of Accepted Facts on the case. Many times the physicians were cited by name in the decision letters. (M.J. O'Leary, unpublished data, CNIC Office of Workers' Compensation, Philadelphia, Pennsylvania) These letters are not available in the public domain, but there are three published decisions of the ECAB in which they name the Navy physician and use the argument posed in the case to help decide the appeal.<sup>14-16</sup>

Another argument was that the OWCP claims examiners would have decided the case regardless of what the

physicians opined. This argument is more difficult to address, and it goes to the source of the authors' motivation in describing the program in this article. The result of the *z*-test comparing acceptance rates for the study population (72%) to the Navy-wide acceptance rate (87.5%) creates many more questions than it answers. The selection bias that has already been noted might be a reason why the difference exists. Other explanations might include the fact that there was a big difference in the case mix between the two groups. The majority of cases referred to the Navy physicians in the study were illness claims, and they are predominantly chronic in nature. A large proportion of the claims seen in the comparison group are injury claims, and these types of cases are much more cut-and-dried. The physician's review opinions might actually be the explanation for the difference, given that the Navy physician's exact words were used in some of the case decisions. The difference is not likely due to chance, but we cannot determine the reason based on the available data. In any case, the differences in the acceptance rates seen between the study population and the total population potentially represent tens of millions of dollars in future cost to be avoided if unsubstantiated claims are not accepted for payment. The uncertainty as to why the difference exists, coupled with the potential cost savings, argues for a better study design to test the hypothesis that the physician opinion letters affect case outcome.

The economic impact of the physician opinions has always been controversial. There was no issue of an incremental cost increase to the Department of the Navy by adding the physicians' assistance. The case load was spread to a group of Occupational Medicine physicians who had experience in the Federal workers' compensation system, and they performed the service in addition to their regular duties. The claims processing infrastructure already existed, and it was staffed to handle this process without additional personnel. However, the "cost avoided" by a denied claim is very difficult to assess (similar to that of an illness avoided by immunization). The chargeback cost to the Navy in 2009 was \$240,003,716.<sup>17</sup> The number of new claims accepted in that year was 5,025 (R. Slighter, unpublished data), a per claim cost of \$47,762. This overstates the per claim cost, as the chargeback cost contains benefits paid on claims from prior years. There are beneficiaries in the system that are collecting full benefits of the FECA that are in their 90s.<sup>18</sup> This is because the FECA currently allows for payment as long as the beneficiary is certified as unable to perform the work they left because of the injury or illness. It makes no difference whether they are incapable of doing the work again as a result of their increasing age or from other conditions that they have suffered in the interim. Applying a cost per diagnosis code is difficult because a case can have multiple diagnosis codes assigned to it, and they are not assigned in order of importance. In any case, this type of data is not maintained by the CPMS. It is not known if the Department of Labor keeps statistics on cost that might be used to assess the economic impact of the Agency physician's input into the claim record.

## CONCLUSIONS

The authors' intent in writing this article was to communicate the outcome of the project and to encourage other agencies in the Federal government to implement similar programs. Although this project's results pertain to agencies of the Federal government and their employees seeking compensation under the FECA, the concept of using the employer's physician to provide input into the claim may possibly be applied to State Workers' Compensation Programs.

Because the referred cases are neither a representative nor a random sample of the worker population, conclusions about the association of certain injuries or illnesses with worker age or gender cannot be reached with any degree of certainty. The reason, or reasons, for the difference in the acceptance rates seen between the study population and the total claim population cannot be discerned from this preliminary descriptive study. The possible economic effect of using medical review provides motivation to carry this project forward. The limitations noted in this preliminary study argue for a better study design. A prospective cohort study where groups of randomly selected matched claims are split into two populations, one that will receive physician review and one that will not, may help establish whether there is a real difference in acceptance rates. It would also be most helpful to have the benefit of a financial analysis that can elucidate an acceptable metric of cost avoidance.

## ACKNOWLEDGMENT

We thank Mr. M. Joseph O'Leary and Mr. Joseph DiDomenico at the CNIC Worker's Compensation Office, Philadelphia Naval Business Center, Philadelphia, Pennsylvania, for their assistance in facilitating the completion of this project.

## REFERENCES

1. Nordlund WJ: The Federal Employees' Compensation Act. *Monthly Labor Review* September 1991; 114: 12.
2. US Department of Labor, Office of Workers Compensation. OWCP Annual Report to Congress FY 2009. Washington, DC, U.S. Department of Labor, July 2, 2009. Available at <https://63.106.133.245/owcp/09owcpmx.pdf>; accessed July 11, 2011.
3. GAO. Federal Employees' Compensation Act—Issues Associated With Changing Benefits for Older Beneficiaries. Washington, DC, GAO, 1996. Available at <http://www.gao.gov/archive/1996/gg96138b.pdf>; accessed July 11, 2011.
4. Ladou J: Federal Employees' Compensation Act. *Int J Occup Environ Health* 2009; 15: 180–94.
5. Toossi M: Labor force projections to 2018: older workers staying more active. *Monthly Labor Review* November 2009; 132: 21.
6. Office of Workers Compensation Programs. OWCP Claims Procedure Manual, Section 2-0805-3. Washington, DC, U.S. Department of Labor, 2010. Available at <http://www.dol.gov/owcp/dfec/regs/compliance/DFECfolio/FECA-PT2.pdf>; accessed July 11, 2011.
7. Office of Workers Compensation Programs. OWCP Claims Procedure Manual, Section 2-0810-4. Washington, DC, U.S. Department of Labor, 2010. Available at <http://www.dol.gov/owcp/dfec/regs/compliance/DFECfolio/FECA-PT2.pdf>; accessed July 11, 2011.
8. Jekel JF, Katz DL, Elmore JG: *Epidemiology, Biostatistics, and Preventive Medicine*, Ed 2. Philadelphia, PA, W.B. Saunders, 2001.

9. Office of Personnel Management. Federal Civilian Workforce Statistics, The Fact Book—2007 Edition. Washington, DC, OPM, 2007. Available at <http://www.opm.gov/feddata/FactBook/2007/TOC.asp>; accessed July 11, 2011.
  10. Office of Workers Compensation Programs. OWCP Claims Procedure Manual, Section 2-0808-5(2). Washington, DC, U.S. Department of Labor, 2010. Available at <http://www.dol.gov/owcp/dfec/regs/compliance/DFECfolio/FECA-PT2.pdf>; accessed July 11, 2011.
  11. Larson LK: Larson's Workers' Compensation Law: Cases, Materials and Text, Ed 3. Albany, NY, Matthew Bender, 2000.
  12. 59 ECAB 07-1607. D.F., Appellant vs. U.S. Postal Service, Post Office, Indianapolis, IN, Employer. Washington, DC, U.S. Department of Labor Employee Compensation Appeals Board, 2007. Available at <http://www.dol.gov/ecab/decisions/2007/Dec/07-1607P.htm>; accessed July 11, 2011.
  13. 39 ECAB 132. Steven R. Piper. Washington, DC, U.S. Department of Labor Employee Compensation Appeals Board, 1987. Available at <http://www.dol.gov/ecab/decisions/2005/Apr/04-0883.htm>; accessed July 11, 2011.
  14. ECAB 07-944. W.K., Appellant vs. Department of the Navy, Philadelphia Naval Shipyard, Philadelphia, PA, Employer. Washington, DC, U.S. Department of Labor Employee Compensation Appeals Board, 2007. Available at <http://www.dol.gov/ecab/decisions/2007/Aug/07-0944.htm>; accessed July 11, 2011.
  15. ECAB 07-674. J.E., Appellant vs. Department of the Navy, Charleston Naval Shipyard, Charleston, SC, Employer. Washington, DC, U.S. Department of Labor Employee Compensation Appeals Board, 2007. Available at <http://www.dol.gov/ecab/decisions/2007/Jul/07-0674.htm>; accessed July 11, 2011.
  16. ECAB 09-1333. D.S. Appellant vs. Department of the Navy, Naval Submarine Base, Groton, CT, Employer. Washington, DC, U.S. Department of Labor Employee Compensation Appeals Board, 2010. Available at: <http://www.dol.gov/ecab/decisions/2010/Apr/09-1333.htm>; accessed July 11, 2011.
  17. U.S. Department of Labor, Office of the Chief Financial Officer. Liability for Current Federal Employees' Compensation Act Benefits. Washington, DC, U.S. Department of Labor, 2010. Available at [http://www.dol.gov/ocfo/media/reports/FECA\\_liability\\_2009\\_3q.pdf](http://www.dol.gov/ocfo/media/reports/FECA_liability_2009_3q.pdf); accessed July 11, 2011.
  18. Simpson AG: Senator Targets Workers' Compensation Pay to Elderly Federal Employees. Insurance Journal, January 18, 2011. Available at <http://www.insurancejournal.com/news/national/2011/01/18/180828.htm>; accessed July 11, 2011.
-