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20

Parts 1 to 399

Revised as of April 1, 2007

Employees' Benefits

Containing a codification of documents of general applicability and future effect

As of April 1, 2007

With Ancillaries

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Cite this Code: CFR

To cite the regulations in this volume use title, part and section number. Thus, 20 CFR 1.1 *refers to title 20, part 1, section 1.*

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Each volume of the Code is revised at least once each calendar year and issued on a quarterly basis approximately as follows:

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Title 17 through Title 27.....as of April 1
Title 28 through Title 41.....as of July 1
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RAYMOND A. MOSLEY,
Director,
Office of the Federal Register.

April 1, 2007.

THIS TITLE

Title 20—EMPLOYEES' BENEFITS is composed of three volumes. The first volume, containing parts 1–399, includes all current regulations issued by the Office of Workers' Compensation Programs, Department of Labor and the Railroad Retirement Board. The second volume, containing parts 400–499, includes all current regulations issued by the Social Security Administration. The third volume, containing part 500 to End, includes all current regulations issued by the Employees' Compensation Appeals Board, the Employment and Training Administration, the Employment Standards Administration, the Benefits Review Board, the Office of the Assistant Secretary for Veterans' Employment and Training (all of the Department of Labor) and the Joint Board for the Enrollment of Actuaries. The contents of these volumes represent all current regulations codified under this title of the CFR as of April 1, 2007.

For this volume, Robert J. Sheehan was Chief Editor. The Code of Federal Regulations publication program is under the direction of Frances D. McDonald, assisted by Ann Worley.

Title 20—Employees' Benefits

(This book contains parts 1 to 399)

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SUBCHAPTER A—ORGANIZATION AND PROCEDURES

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1.2 What functions are assigned to OWCP?
1.3 What rules are contained in this chapter?
1.4 Where are other rules concerning OWCP functions found?
1.5 When was the former Bureau of Employees' Compensation abolished?
1.6 How were many of OWCP's current functions administered in the past?

AUTHORITY: 5 U.S.C. 301, 8145 and 8149 (Reorganization Plan No. 6 of 1950, 15 FR 3174, 3 CFR, 1949–1953 Comp., p. 1004, 64 Stat. 1263); 42 U.S.C. 7384d and 7385s–10; Executive Order 13179, 65 FR 77487, 3 CFR, 2000 Comp., p. 321; Secretary of Labor's Order No. 13–71, 36 FR 8155; Employment Standards Order No. 2–74, 39 FR 34722.

SOURCE: 71 FR 78533, Dec. 29, 2006 unless otherwise noted.

§ 1.1 Under what authority was the Office of Workers' Compensation Programs established?

The Assistant Secretary of Labor for Employment Standards, by authority vested in him by the Secretary of Labor in Secretary's Order No. 13–71 (36 FR 8755), established in the Employment Standards Administration an Office of Workers' Compensation Programs (OWCP) by Employment Standards Order No. 2–74 (39 FR 34722). The Assistant Secretary subsequently designated as the head thereof a Director who, under the general supervision of the Assistant Secretary, administers the programs assigned to OWCP by the Assistant Secretary.

§ 1.2 What functions are assigned to OWCP?

The Assistant Secretary of Labor for Employment Standards has delegated authority and assigned responsibility to the Director of OWCP for the Department of Labor's programs under the following statutes:

(a) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101 *et seq.*), except 5 U.S.C. 8149 as it pertains to the Employees' Compensation Appeals Board.

(b) The War Hazards Compensation Act (42 U.S.C. 1701 *et seq.*).

(c) The War Claims Act (50 U.S.C. App. 2003).

(d) The Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (42 U.S.C. 7384 *et seq.*), except activities, pursuant to Executive Order 13179 (''Providing Compensation to America's Nuclear Weapons Workers'') of December 7, 2000, assigned to the Secretary of Health and Human Services, the Secretary of Energy and the Attorney General.

(e) The Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 *et seq.*), except: 33 U.S.C. 919(d) with respect to administrative law judges in the Office of Administrative Law Judges; 33 U.S.C. 921(b) as it pertains to the Benefits Review Board; and activities, pursuant to 33 U.S.C. 941, assigned to the Assistant Secretary of Labor for Occupational Safety and Health.

(f) The Black Lung Benefits Act, as amended (30 U.S.C. 901 *et seq.*).

§ 1.3 What rules are contained in this chapter?

The rules in this chapter are those governing the OWCP functions under the Federal Employees' Compensation Act, the War Hazards Compensation Act, the War Claims Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

§ 1.4 Where are other rules concerning OWCP functions found?

(a) The rules of the OWCP governing its functions under the Longshore and Harbor Workers' Compensation Act and its extensions are set forth in subchapter A of chapter VI of this title.

(b) The rules of the OWCP governing its functions under the Black Lung Benefits Act program are set forth in subchapter B of chapter VI of this title.

(c) The rules and regulations of the Employees' Compensation Appeals Board are set forth in chapter IV of this title.

(d) The rules and regulations of the Benefits Review Board are set forth in Chapter VII of this title.

§ 1.5 When was the former Bureau of Employees' Compensation abolished?

By Secretary of Labor's Order issued September 23, 1974 (39 FR 34723), issued concurrently with Employment Standards Order 2–74 (39 FR 34722), the Secretary revoked the prior Secretary's Order No. 18–67 (32 FR 12979), which had delegated authority and assigned responsibility for the various workers' compensation programs enumerated in §1.2, except the Black Lung Benefits Program and the Energy Employees Occupational Illness Compensation Program not then in existence, to the Director of the former Bureau of Employees' Compensation.

§ 1.6 How were many of OWCP's current functions administered in the past?

(a) Administration of the Federal Employees' Compensation Act and the Longshore and Harbor Workers' Compensation Act was initially vested in an independent establishment known as the U.S. Employees' Compensation Commission. By Reorganization Plan No. 2 of 1946 (3 CFR, 1943–1949 Comp., p. 1064; 60 Stat. 1095, effective July 16, 1946), the Commission was abolished and its functions were transferred to the Federal Security Agency to be performed by a newly created Bureau of Employees' Compensation within such Agency. By Reorganization Plan No. 19 of 1950 (15 FR 3178, 3 CFR, 1949–1954 Comp., page 1010, 64 Stat. 1271), said Bureau was transferred to the Department of Labor (DOL), and the authority formerly vested in the Administrator, Federal Security Agency, was vested in the Secretary of Labor. By Reorganization Plan No. 6 of 1950 (15 FR 3174, 3 CFR, 1949–1953 Comp., page 1004, 64 Stat. 1263), the Secretary of Labor was authorized to make from time to time such provisions as he shall deem appropriate, authorizing the performance of any of his functions by any other officer, agency, or employee of the DOL.

(b) In 1972, two separate organizational units were established within the Bureau: an Office of Workmen's Compensation Programs (37 FR 20533) and an Office of Federal Employees' Compensation (37 FR 22979). In 1974, these two units were abolished and one organizational unit, the Office of Workers' Compensation Programs, was established in lieu of the Bureau of Employees' Compensation (39 FR 34722).

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AUTHORITY: 5 U.S.C. 301, 8103, 8145 and 8149; 31 U.S.C. 3716 and 3717; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 5–96, 62 FR 107.

SOURCE: 63 FR 65306, Nov. 25, 1998, unless otherwise noted.

Subpart A—General Provisions

INTRODUCTION

§ 10.0 What are the provisions of the FECA, in general?

The Federal Employees' Compensation Act (FECA) as amended (5 U.S.C. 8101 et seq.) provides for the payment of workers' compensation benefits to civilian officers and employees of all

branches of the Government of the United States. The regulations in this part describe the rules for filing, processing, and paying claims for benefits under the FECA. Proceedings under the FECA are non-adversarial in nature.

(a) The FECA has been amended and extended a number of times to provide workers' compensation benefits to volunteers in the Civil Air Patrol (5 U.S.C. 8141), members of the Reserve Officers' Training Corps (5 U.S.C. 8140), Peace Corps Volunteers (5 U.S.C. 8142), Job Corps enrollees and Volunteers in Service to America (5 U.S.C. 8143), members of the National Teachers Corps (5 U.S.C. 8143a), certain student employees (5 U.S.C. 5351 and 8144), certain law enforcement officers not employed by the United States (5 U.S.C. 8191–8193), and various other classes of persons who provide or have provided services to the Government of the United States.

(b) The FECA provides for payment of several types of benefits, including compensation for wage loss, schedule awards, medical and related benefits, and vocational rehabilitation services for conditions resulting from injuries sustained in performance of duty while in service to the United States.

(c) The FECA also provides for payment of monetary compensation to specified survivors of an employee whose death resulted from a work-related injury and for payment of certain burial expenses subject to the provisions of 5 U.S.C. 8134.

(d) All types of benefits and conditions of eligibility listed in this section are subject to the provisions of the FECA and of this part. This section shall not be construed to modify or enlarge upon the provisions of the FECA.

§ 10.1 What rules govern the administration of the FECA and this chapter?

In accordance with 5 U.S.C. 8145 and Secretary's Order 5–96, the responsibility for administering the FECA, except for 5 U.S.C. 8149 as it pertains to the Employees' Compensation Appeals Board, has been delegated to the Assistant Secretary for Employment Standards. The Assistant Secretary, in turn, has delegated the authority and responsibility for administering the FECA to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director, OWCP and his or her designees have the exclusive authority to administer, interpret and enforce the provisions of the Act.

§ 10.2 What do these regulations contain?

This part 10 sets forth the regulations governing administration of all claims filed under the FECA, except to the extent specified in certain particular provisions. Its provisions are intended to assist persons seeking compensation benefits under the FECA, as well as personnel in the various Federal agencies and the Department of Labor who process claims filed under the FECA or who perform administrative functions with respect to the FECA. This part 10 applies to part 25 of this chapter except as modified by part 25. The various subparts of this part contain the following:

(a) Subpart A: The general statutory and administrative framework for processing claims under the FECA. It contains a statement of purpose and scope, together with definitions of terms, descriptions of basic forms, information about the disclosure of OWCP records, and a description of rights and penalties under the FECA, including convictions for fraud.

(b) Subpart B: The rules for filing notices of injury and claims for benefits under the FECA. It also addresses evidence and burden of proof, as well as the process of making decisions concerning eligibility for benefits.

(c) Subpart C: The rules governing claims for and payment of continuation of pay.

(d) Subpart D: The rules governing emergency and routine medical care, second opinion and referee medical examinations directed by OWCP, and medical reports and records in general. It also addresses the kinds of treatment which may be authorized and how medical bills are paid.

(e) Subpart E: The rules relating to the payment of monetary compensation benefits for disability, impairment and death. It includes the provisions for identifying and processing overpayments of compensation.

(f) Subpart F: The rules governing the payment of continuing compensation benefits. It includes provisions concerning the employee's and the employer's responsibilities in returning the employee to work. It also contains provisions governing reports of earnings and dependents, recurrences, and reduction and termination of compensation benefits.

(g) Subpart G: The rules governing the appeals of decisions under the FECA. It includes provisions relating to hearings, reconsiderations, and appeals before the Employees' Compensation Appeals Board.

(h) Subpart H: The rules concerning legal representation and for adjustment and recovery from a third party. It also contains provisions relevant to three groups of employees whose status requires special application of the provisions of the FECA: Federal grand and petit jurors, Peace Corps volunteers, and non-Federal law enforcement officers.

(i) Subpart I: Information for medical providers. It includes rules for medical reports, medical bills, and the OWCP medical fee schedule, as well as the provisions for exclusion of medical providers.

§ 10.3 Have the collection of information requirements of this part been approved by the Office of Management and Budget (OMB)?

The collection of information requirements in this part have been approved by OMB and assigned OMB control numbers 1215–0055, 1215–0067, 1215–0078, 1215–0103, 1215–0105, 1215–0115, 1215–0116, 1215–0144, 1215–0151, 1215–0154, 1215–0155, 1215–0161, 1215–0167, 1215–0176, 1215–0178, 1215–0182, 1215–0193 and 1215–0194.

Definitions and Forms

§ 10.5 What definitions apply to these regulations?

Certain words and phrases found in this part are defined in this section or in the FECA. Some other words and phrases that are used only in limited situations are defined in the later subparts of these regulations.

(a) *Benefits* or *Compensation* means the money OWCP pays to or on behalf of a beneficiary from the Employees' Compensation Fund for lost wages, a loss of wage-earning capacity or a permanent physical impairment, as well as the money paid to beneficiaries for an employee's death. These two terms also include any other amounts paid out of the Employees' Compensation Fund for such things as medical treatment, medical examinations conducted at the request of OWCP as part of the claims adjudication process, vocational rehabilitation services, services of an attendant and funeral expenses, but does not include continuation of pay.

(b) *Beneficiary* means an individual who is entitled to a benefit under the FECA and this part.

(c) *Claim* means a written assertion of an individual's entitlement to benefits under the FECA, submitted in a manner authorized by this part.

(d) *Claimant* means an individual whose claim has been filed.

(e) *Director* means the Director of OWCP or a person designated to carry out his or her functions.

(f) *Disability* means the incapacity, because of an employment injury, to earn the wages the employee was receiving at the time of injury. It may be partial or total.

(g) *Earnings from employment or self-employment* means:

(1) Gross earnings or wages before any deductions and includes the value of subsistence, quarters, reimbursed expenses and any other goods or services received in kind as remuneration; or

(2) A reasonable estimate of the cost to have someone else perform the duties of an individual who accepts no remuneration. Neither lack of profits, nor the characterization of the duties as a hobby, removes an unremunerated individual's responsibility to report the estimated cost to have someone else perform his or her duties.

(h) *Employee* means, but is not limited to, an individual who fits within one of the following listed groups:

(1) A civil officer or employee in any branch of the Government of the United States, including an officer or employee of an instrumentality wholly owned by the United States;

(2) An individual rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay, when a statute

authorizes the acceptance or use of the service, or authorizes payment of travel or other expenses of the individual;

(3) An individual, other than an independent contractor or an individual employed by an independent contractor, employed on the Menominee Indian Reservation in Wisconsin in operations conducted under a statute relating to tribal timber and logging operations on that reservation;

(4) An individual appointed to a position on the office staff of a former President; or

(5) An individual selected and serving as a Federal petit or grand juror.

(i) *Employer or Agency* means any civil agency or instrumentality of the United States Government, or any other organization, group or institution employing an individual defined as an ''employee'' by this section. These terms also refer to officers and employees of an employer having responsibility for the supervision, direction or control of employees of that employer as an ''immediate superior,'' and to other employees designated by the employer to carry out the functions vested in the employer under the FECA and this part, including officers or employees delegated responsibility by an employer for authorizing medical treatment for injured employees.

(j) *Entitlement* means entitlement to benefits as determined by OWCP under the FECA and the procedures described in this part.

(k) *FECA* means the Federal Employees' Compensation Act, as amended.

(l) *Hospital services* means services and supplies provided by hospitals within the scope of their practice as defined by State law.

(m) *Impairment* means any anatomic or functional abnormality or loss. A permanent impairment is any such abnormality or loss after maximum medical improvement has been achieved.

(n) *Knowingly* means with knowledge, consciously, willfully or intentionally.

(o) *Medical services* means services and supplies provided by or under the supervision of a physician. Reimbursable chiropractic services are limited to physical examinations (and related laboratory tests), x-rays performed to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation.

(p) *Medical support services* means services, drugs, supplies and appliances provided by a person other than a physician or hospital.

(q) *Occupational disease* or *Illness* means a condition produced by the work environment over a period longer than a single workday or shift.

(r) *OWCP* means the Office of Workers' Compensation Programs.

(s) *Pay rate for compensation purposes* means the employee's pay, as determined under 5 U.S.C. 8114, at the time of injury, the time disability begins or the time compensable disability recurs if the recurrence begins more than six months after the injured employee resumes regular full-time employment with the United States, whichever is greater, except as otherwise determined under 5 U.S.C. 8113 with respect to any period.

(t) *Physician* means an individual defined as such in 5 U.S.C. 8101(2), except during the period for which his or her license to practice medicine has been suspended or revoked by a State licensing or regulatory authority.

(u) *Qualified hospital* means any hospital licensed as such under State law which has not been excluded under the provisions of subpart I of this part. Except as otherwise provided by regulation, a qualified hospital shall be deemed to be designated or approved by OWCP.

(v) *Qualified physician* means any physician who has not been excluded under the provisions of subpart I of this part. Except as otherwise provided by regulation, a qualified physician shall be deemed to be designated or approved by OWCP.

(w) *Qualified provider of medical support services or supplies* means any person, other than a physician or a hospital, who provides services, drugs, supplies and appliances for which OWCP makes payment, who possesses any applicable licenses required under State law, and who has not been excluded under the provisions of subpart I of this part.

(x) *Recurrence of disability* means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition

which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness. This term also means an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, non-performance of job duties or a reduction-in-force), or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.

(y) *Recurrence of medical condition* means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage. Continuous treatment for the original condition or injury is not considered a ''need for further medical treatment after release from treatment,'' nor is an examination without treatment.

(z) *Representative* means an individual properly authorized by a claimant in writing to act for the claimant in connection with a claim or proceeding under the FECA or this part.

(aa) *Student* means an individual defined at 5 U.S.C. 8101(17). Two terms used in that particular definition are further defined as follows:

(1) *Additional type of educational or training institution* means a technical, trade, vocational, business or professional school accredited or licensed by the United States Government or a State Government or any political subdivision thereof providing courses of not less than three months duration, that prepares the individual for a livelihood in a trade, industry, vocation or profession.

(2) *Year beyond the high school level* means:

(i) The 12-month period beginning the month after the individual graduates from high school, provided he or she had indicated an intention to continue schooling within four months of high school graduation, and each successive 12-month period in which there is school attendance or the payment of compensation based on such attendance; or

(ii) If the individual has indicated that he or she will not continue schooling within four months of high school graduation, the 12-month period beginning with the month that the individual enters school to continue his or her education, and each successive 12-month period in which there is school attendance or the payment of compensation based on such attendance.

(bb) *Subluxation* means an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae which must be demonstrable on any x-ray film to an individual trained in the reading of x-rays.

(cc) *Surviving spouse* means the husband or wife living with or dependent for support upon a deceased employee at the time of his or her death, or living apart for reasonable cause or because of the deceased employee's desertion.

(dd) *Temporary aggravation* of a preexisting condition means that factors of employment have directly caused that condition to be more severe for a limited period of time and have left no greater impairment than existed prior to the employment injury.

(ee) *Traumatic injury* means a condition of the body caused by a specific event or incident, or series of events or incidents, within a single workday or shift. Such condition must be caused by external force, including stress or strain, which is identifiable as to time and place of occurrence and member or function of the body affected.

§ 10.6 What special statutory definitions apply to dependents and survivors?

(a) 5 U.S.C. 8133 provides that certain benefits are payable to certain enumerated survivors of employees who have died from an injury sustained in the performance of duty.

(b) 5 U.S.C. 8148 also provides that certain other benefits may be payable to certain family members of employees who have been incarcerated due to a felony conviction.

(c) 5 U.S.C. 8110(b) further provides that any employee who is found to be

eligible for a basic benefit shall be entitled to have such basic benefit augmented at a specified rate for certain persons who live in the beneficiary's household or who are dependent upon the beneficiary for support.

(d) 5 U.S.C. 8101, 8110, 8133 and 8148, which define the nature of such survivorship or dependency necessary to qualify a beneficiary for a survivor's benefit or an augmented benefit, apply to the provisions of this part.

§ 10.7 What forms are needed to process claims under the FECA?

(a) Notice of injury, claims and certain specified reports shall be made on forms prescribed by OWCP. Employers shall not modify these forms or use substitute forms. Employers are expected to maintain an adequate supply of the basic forms needed for the proper recording and reporting of injuries.

Form No.	Title
(1) CA–1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/ Compensation
(2) CA–2	Notice of Occupational Disease and Claim for Compensation
(3) CA–2a	Notice of Employee's Recurrence of Disability and Claim for Pay/ Compensation
(4) CA–5	Claim for Compensation by Widow, Widower and/or Children
(5) CA–5b	Claim for Compensation by Parents, Brothers, Sisters, Grandparents, or Grandchildren
(6) CA–6	Official Superior's Report of Employee's Death
(7) CA–7	Claim for Compensation Due to Traumatic Injury or Occupational Disease
(8) CA–7a	Time Analysis Form
(9) CA–7b	Leave Buy Back (LBB) Worksheet/Certification and Election
(10) CA–16	Authorization of Examination and/or Treatment
(11) CA–17	Duty Status Report
(12) CA–20	Attending Physician's Report

(b) Copies of the forms listed in this paragraph are available for public inspection at the Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from district offices, employers (i.e., safety and health offices, supervisors), and the Internet, at *www.dol.gov./dol/esa/owcp.htm.*

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

INFORMATION IN PROGRAM RECORDS

§ 10.10 Are all documents relating to claims filed under the FECA considered confidential?

All records relating to claims for benefits, including copies of such records maintained by an employer, are considered confidential and may not be released, inspected, copied or otherwise disclosed except as provided in the Freedom of Information Act and the Privacy Act of 1974.

§ 10.11 Who maintains custody and control of FECA records?

All records relating to claims for benefits filed under the FECA, including any copies of such records maintained by an employing agency, are covered by the government-wide Privacy Act system of records entitled DOL/GOVT–1 (Office of Workers' Compensation Programs, Federal Employees' Compensation Act File). This system of records is maintained by and under the control of OWCP, and, as such, all records covered by DOL/GOVT–1 are official records of OWCP. The protection, release, inspection and copying of records covered by DOL/GOVT–1 shall be accomplished in accordance with the rules, guidelines and provisions of this part, as well as those contained in 29 CFR parts 70 and 71, and with the notice of the system of records and routine uses published in the FEDERAL REGISTER. All questions relating to access/disclosure, and/or amendment of FECA records maintained by OWCP or the employing agency, are to be resolved in accordance with this section.

§ 10.12 How may a FECA claimant or beneficiary obtain copies of protected records?

(a) A claimant seeking copies of his or her official FECA file should address a request to the District Director of the OWCP office having custody of the file. A claimant seeking copies of FECA-related documents in the custody of the employer should follow the procedures established by that agency.

(b)(1) While an employing agency may establish procedures that an injured employee or beneficiary should

follow in requesting access to documents it maintains, any decision issued in response to such a request must comply with the rules and regulations of the Department of Labor which govern all other aspects of safeguarding these records.

(2) No employing agency has the authority to issue determinations with respect to requests for the correction or amendment of records contained in or covered by DOL/GOVT–1. That authority is within the exclusive control of OWCP. Thus, any request for correction or amendment received by an employing agency must be referred to OWCP for review and decision.

(3) Any administrative appeal taken from a denial issued by the employing agency or OWCP shall be filed with the Solicitor of Labor in accordance with 29 CFR 71.7 and 71.9.

§ 10.13 What process is used by a person who wants to correct FECA-related documents?

Any request to amend a record covered by DOL/GOVT–1 should be directed to the district office having custody of the official file. No employer has the authority to issue determinations with regard to requests for the correction of records contained in or covered by DOL/GOVT–1. Any request for correction received by an employer must be referred to OWCP for review and decision.

RIGHTS AND PENALTIES

§ 10.15 May compensation rights be waived?

No employer or other person may require an employee or other claimant to enter into any agreement, either before or after an injury or death, to waive his or her right to claim compensation under the FECA. No waiver of compensation rights shall be valid.

§ 10.16 What criminal penalties may be imposed in connection with a claim under the FECA?

(a) A number of statutory provisions make it a crime to file a false or fraudulent claim or statement with the Government in connection with a claim under the FECA, or to wrongfully impede a FECA claim. Included among these provisions are sections 287, 1001, 1920, and 1922 of title 18, United States Code. Enforcement of these and other criminal provisions that may apply to claims under the FECA are within the jurisdiction of the Department of Justice.

(b) In addition, administrative proceedings may be initiated under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. 3801–12, to impose civil penalties and assessments against persons who make, submit, or present, or cause to be made, submitted or presented, false, fictitious or fraudulent claims or written statements to OWCP in connection with a claim under the FECA. The Department of Labor's regulations implementing the PFRCA are found at 29 CFR part 22.

§ 10.17 Is a beneficiary who defrauds the Government in connection with a claim for benefits still entitled to those benefits?

When a beneficiary either pleads guilty to or is found guilty on either Federal or State criminal charges of defrauding the Federal Government in connection with a claim for benefits, the beneficiary's entitlement to any further compensation benefits will terminate effective the date either the guilty plea is accepted or a verdict of guilty is returned after trial, for any injury occurring on or before the date of such guilty plea or verdict. Termination of entitlement under this section is not affected by any subsequent change in or recurrence of the beneficiary's medical condition.

§ 10.18 Can a beneficiary who is incarcerated based on a felony conviction still receive benefits?

(a) Whenever a beneficiary is incarcerated in a State or Federal jail, prison, penal institution or other correctional facility due to a State or Federal felony conviction, he or she forfeits all rights to compensation benefits during the period of incarceration. A beneficiary's right to compensation benefits for the period of his or her incarceration is not restored after such incarceration ends, even though payment of compensation benefits may resume.

(b) If the beneficiary has eligible dependents, OWCP will pay compensation

to such dependents at a reduced rate during the period of his or her incarceration, by applying the percentages of 5 U.S.C. 8133(a)(1) through (5) to the beneficiary's gross current entitlement rather than to the beneficiary's monthly pay.

(c) If OWCP's decision on entitlement is pending when the period of incarceration begins, and compensation is due for a period of time prior to such incarceration, payment for that period will only be made to the beneficiary following his or her release.

Subpart B—Filing Notices and Claims; Submitting Evidence

NOTICES AND CLAIMS FOR INJURY, DISEASE, AND DEATH—EMPLOYEE OR SURVIVOR'S ACTIONS

§ 10.100 How and when is a notice of traumatic injury filed?

(a) To claim benefits under the FECA, an employee who sustains a work-related traumatic injury must give notice of the injury in writing on Form CA–1, which may be obtained from the employer or from the Internet at *www.dol.gov./dol/esa/owcp.htm.* The employee must forward this notice to the employer. Another person, including the employer, may give notice of injury on the employee's behalf. The person submitting a notice shall include the Social Security Number (SSN) of the injured employee.

(b) For injuries sustained on or after September 7, 1974, a notice of injury must be filed within three years of the injury. (The form contains the necessary words of claim.) The requirements for filing notice are further described in 5 U.S.C. 8119. Also see §10.205 concerning time requirements for filing claims for continuation of pay.

(1) If the claim is not filed within three years, compensation may still be allowed if notice of injury was given within 30 days or the employer had actual knowledge of the injury or death within 30 days after occurrence. This knowledge may consist of written records or verbal notification. An entry into an employee's medical record may also satisfy this requirement if it is sufficient to place the employer on notice of a possible work-related injury or disease.

(2) OWCP may excuse failure to comply with the three-year time requirement because of truly exceptional circumstances (for example, being held prisoner of war).

(3) The claimant may withdraw his or her claim (but not the notice of injury) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits. Any continuation of pay (COP) granted to an employee after a claim is withdrawn must be charged to sick or annual leave, or considered an overpayment of pay consistent with 5 U.S.C. 5584, at the employee's option.

(c) However, in cases of latent disability, the time for filing claim does not begin to run until the employee has a compensable disability and is aware, or reasonably should have been aware, of the causal relationship between the disability and the employment (see 5 U.S.C. 8122(b)).

§ 10.101 How and when is a notice of occupational disease filed?

(a) To claim benefits under the FECA, an employee who has a disease which he or she believes to be work-related must give notice of the condition in writing on Form CA–2, which may be obtained from the employer or from the Internet at *www.dol.gov./dol/esa/owcp.htm.* The employee must forward this notice to the employer. Another person, including the employer, may do so on the employee's behalf. The person submitting a notice shall include the Social Security Number (SSN) of the injured employee. The claimant may withdraw his or her claim (but not the notice of occupational disease) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits.

(b) For occupational diseases sustained as a result of exposure to injurious work factors that occurs on or after September 7, 1974, a notice of occupational disease must be filed within three years of the onset of the condition. (The form contains the necessary words of claim.) The requirements for timely filing are described in §10.100(b)(1) through (3).

(c) However, in cases of latent disability, the time for filing claim does not begin to run until the employee has a compensable disability and is aware, or reasonably should have been aware, of the causal relationship between the disability and the employment (see 5 U.S.C. 8122(b)).

§ 10.102 How and when is a claim for wage loss compensation filed?

(a) Form CA–7 is used to claim compensation for periods of disability not covered by COP.

(1) An employee who is disabled with loss of pay for more than three calendar days due to an injury, or someone acting on his or her behalf, must file Form CA–7 before compensation can be paid.

(2) The employee shall complete the front of Form CA–7 and submit the form to the employer for completion and transmission to OWCP. The form should be completed as soon as possible, but no more than 14 calendar days after the date pay stops due to the injury or disease.

(3) The requirements for filing claims are further described in 5 U.S.C. 8121.

(b) Additional Forms CA–7 are used to claim compensation for additional periods of disability after the first Form CA–7 is submitted to OWCP.

(1) It is the employee's responsibility to submit Form CA–7. Without receipt of such claim, OWCP has no knowledge of continuing wage loss. Therefore, while disability continues, the employee should submit a claim on Form CA–7 each two weeks until otherwise instructed by OWCP.

(2) The employee shall complete the front of Form CA–7 and submit the form to the employer for completion and transmission to OWCP.

(3) The employee is responsible for submitting, or arranging for the submittal of, medical evidence to OWCP which establishes both that disability continues and that the disability is due to the work-related injury. Form CA–20 is attached to Form CA–7 for this purpose.

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

§ 10.103 How and when is a claim for permanent impairment filed?

Form CA–7 is used to claim compensation for impairment to a body part covered under the schedule established by 5 U.S.C. 8107. If Form CA–7 has already been filed to claim disability compensation, an employee may file a claim for such impairment by sending a letter to OWCP which specifies the nature of the benefit claimed.

§ 10.104 How and when is a claim for recurrence filed?

(a) A recurrence should be reported on Form CA–2a if it causes the employee to lose time from work and incur a wage loss, or if the employee experiences a renewed need for treatment after previously being released from care. However, a notice of recurrence should not be filed when a new injury, new occupational disease, or new event contributing to an already-existing occupational disease has occurred. In these instances, the employee should file Form CA–1 or CA–2.

(b) The employee has the burden of establishing by the weight of reliable, probative and substantial evidence that the recurrence of disability is causally related to the original injury.

(1) The employee must include a detailed factual statement as described on Form CA–2a. The employer may submit comments concerning the employee's statement.

(2) The employee should arrange for the submittal of a detailed medical report from the attending physician as described on Form CA–2a. The employee should also submit, or arrange for the submittal of, similar medical reports for any examination and/or treatment received after returning to work following the original injury.

§ 10.105 How and when is a notice of death and claim for benefits filed?

(a) If an employee dies from a work-related traumatic injury or an occupational disease, any survivor may file a claim for death benefits using Form CA–5 or CA–5b, which may be obtained from the employer or from the Internet at *www.dol.gov./dol/esa/owcp.htm.* The survivor must provide this notice in writing and forward it to the employer.

Another person, including the employer, may do so on the survivor's behalf. The survivor may also submit the completed Form CA–5 or CA–5b directly to OWCP. The survivor shall disclose the SSNs of all survivors on whose behalf claim for benefits is made in addition to the SSN of the deceased employee. The survivor may withdraw his or her claim (but not the notice of death) by so requesting in writing to OWCP at any time before OWCP determines eligibility for benefits.

(b) For deaths that occur on or after September 7, 1974, a notice of death must be filed within three years of the death. The form contains the necessary words of claim. The requirements for timely filing are described in §10.100(b)(1) through (3).

(c) However, in cases of death due to latent disability, the time for filing the claim does not begin to run until the survivor is aware, or reasonably should have been aware, of the causal relationship between the death and the employment (see 5 U.S.C. 8122(b)).

(d) The filing of a notice of injury or occupational disease will satisfy the time requirements for a death claim based on the same injury or occupational disease. If an injured employee or someone acting on the employee's behalf does not file a claim before the employee's death, the right to claim compensation for disability other than medical expenses ceases and does not survive.

(e) A survivor must be alive to receive any payment; there is no vested right to such payment. A report as described in §10.414 of this part must be filed once each year to support continuing payments of compensation.

NOTICES AND CLAIMS FOR INJURY, DISEASE, AND DEATH—EMPLOYER'S ACTIONS

§10.110 What should the employer do when an employee files a notice of traumatic injury or occupational disease?

(a) The employer shall complete the agency portion of Form CA–1 (for traumatic injury) or CA–2 (for occupational disease) no more than 10 working days after receipt of notice from the employee. The employer shall also complete the Receipt of Notice and give it to the employee, along with copies of both sides of Form CA–1 or Form CA–2.

(b) The employer must complete and transmit the form to OWCP within 10 working days after receipt of notice from the employee if the injury or disease will likely result in:

(1) A medical charge against OWCP;

(2) Disability for work beyond the day or shift of injury;

(3) The need for more than two appointments for medical examination and/or treatment on separate days, leading to time loss from work;

(4) Future disability;

(5) Permanent impairment; or

(6) Continuation of pay pursuant to 5 U.S.C. 8118.

(c) The employer should not wait for submittal of supporting evidence before sending the form to OWCP.

(d) If none of the conditions in paragraph (b) of this section applies, the Form CA–1 or CA–2 shall be retained as a permanent record in the Employee Medical Folder in accordance with the guidelines established by the Office of Personnel Management.

§10.111 What should the employer do when an employee files an initial claim for compensation due to disability or permanent impairment?

(a) When an employee is disabled by a work-related injury and loses pay for more than three calendar days, or has a permanent impairment or serious disfigurement as described in 5 U.S.C. 8107, the employer shall furnish the employee with Form CA–7 for the purpose of claiming compensation.

(b) If the employee is receiving continuation of pay (COP), the employer should give Form CA–7 to the employee by the 30th day of the COP period and submit the form to OWCP by the 40th day of the COP period. If the employee has not returned the form to the employer by the 40th day of the COP period, the employer should ask him or her to submit it as soon as possible.

(c) Upon receipt of Form CA–7 from the employee, or someone acting on his or her behalf, the employer shall complete the appropriate portions of the form. As soon as possible, but no more than five working days after receipt from the employee, the employer shall forward the completed Form CA–7 and

any accompanying medical report to OWCP.

§ 10.112 What should the employer do when an employee files a claim for continuing compensation due to disability?

(a) If the employee continues in a leave-without-pay status due to a work-related injury after the period of compensation initially claimed on Form CA–7, the employer shall furnish the employee with another Form CA–7 for the purpose of claiming continuing compensation.

(b) Upon receipt of Form CA–7 from the employee, or someone acting on his or her behalf, the employer shall complete the appropriate portions of the form. As soon as possible, but no more than five working days after receipt from the employee, the employer shall forward the completed Form CA–7 and any accompanying medical report to OWCP.

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

§ 10.113 What should the employer do when an employee dies from a work-related injury or disease?

(a) The employer shall immediately report a death due to a work-related traumatic injury or occupational disease to OWCP by telephone, telegram, or facsimile (fax). No more than 10 working days after notification of the death, the employer shall complete and send Form CA–6 to OWCP.

(b) When possible, the employer shall furnish a Form CA–5 or CA–5b to all persons likely to be entitled to compensation for death of an employee. The employer should also supply information about completing and filing the form.

(c) The employer shall promptly transmit Form CA–5 or CA–5b to OWCP. The employer shall also promptly transmit to OWCP any other claim or paper submitted which appears to claim compensation on account of death.

Evidence and Burden of Proof

§ 10.115 What evidence is needed to establish a claim?

Forms CA–1, CA–2, CA–5 and CA–5b describe the basic evidence required. OWCP may send any request for additional evidence to the claimant and to his or her representative, if any. Evidence should be submitted in writing. The evidence submitted must be reliable, probative and substantial. Each claim for compensation must meet five requirements before OWCP can accept it. These requirements, which the employee must establish to meet his or her burden of proof, are as follows:

(a) The claim was filed within the time limits specified by the FECA;

(b) The injured person was, at the time of injury, an employee of the United States as defined in 5 U.S.C. 8101(1) and § 10.5(h) of this part;

(c) The fact that an injury, disease or death occurred;

(d) The injury, disease or death occurred while the employee was in the performance of duty; and

(e) The medical condition for which compensation or medical benefits is claimed is causally related to the claimed injury, disease or death. Neither the fact that the condition manifests itself during a period of Federal employment, nor the belief of the claimant that factors of employment caused or aggravated the condition, is sufficient in itself to establish causal relationship.

(f) In all claims, the claimant is responsible for submitting, or arranging for submittal of, a medical report from the attending physician. For wage loss benefits, the claimant must also submit medical evidence showing that the condition claimed is disabling. The rules for submitting medical reports are found in §§ 10.330 through 10.333.

§ 10.116 What additional evidence is needed in cases based on occupational disease?

(a) The employee must submit the specific detailed information described on Form CA-2 and on any checklist (Form CA-35, A-H) provided by the employer. OWCP has developed these checklists to address particular occupational diseases. The medical report

should also include the information specified on the checklist for the particular disease claimed.

(b) The employer should submit the specific detailed information described on Form CA-2 and on any checklist pertaining to the claimed disease.

§ 10.117 What happens if, in any claim, the employer contests any of the facts as stated by the claimant?

(a) An employer who has reason to disagree with any aspect of the claimant's report shall submit a statement to OWCP that specifically describes the factual allegation or argument with which it disagrees and provide evidence or argument to support its position. The employer may include supporting documents such as witness statements, medical reports or records, or any other relevant information.

(b) Any such statement shall be submitted to OWCP with the notice of traumatic injury or death, or within 30 calendar days from the date notice of occupational disease or death is received from the claimant. If the employer does not submit a written explanation to support the disagreement, OWCP may accept the claimant's report of injury as established. The employer may not use a disagreement with an aspect of the claimant's report to delay forwarding the claim to OWCP or to compel or induce the claimant to change or withdraw the claim.

§ 10.118 Does the employer participate in the claims process in any other way?

(a) The employer is responsible for submitting to OWCP all relevant and probative factual and medical evidence in its possession, or which it may acquire through investigation or other means. Such evidence may be submitted at any time.

(b) The employer may ascertain the events surrounding an injury and the extent of disability where it appears that an employee who alleges total disability may be performing other work, or may be engaging in activities which would indicate less than total disability. This authority is in addition to that given in §10.118(a). However, the provisions of the Privacy Act apply to any endeavor by the employer to ascertain the facts of the case (see §§10.10 and 10.11).

(c) The employer does not have the right, except as provided in subpart C of this part, to actively participate in the claims adjudication process.

§ 10.119 What action will OWCP take with respect to information submitted by the employer?

OWCP will consider all evidence submitted appropriately, and OWCP will inform the employee, the employee's representative, if any, and the employer of any action taken. Where an employer contests a claim within 30 days of the initial submittal and the claim is later approved, OWCP will notify the employer of the rationale for approving the claim.

§ 10.120 May a claimant submit additional evidence?

A claimant or a person acting on his or her behalf may submit to OWCP at any time any other evidence relevant to the claim.

§ 10.121 What happens if OWCP needs more evidence from the claimant?

If the claimant submits factual evidence, medical evidence, or both, but OWCP determines that this evidence is not sufficient to meet the burden of proof, OWCP will inform the claimant of the additional evidence needed. The claimant will be allowed at least 30 days to submit the evidence required. OWCP is not required to notify the claimant a second time if the evidence submitted in response to its first request is not sufficient to meet the burden of proof.

DECISIONS ON ENTITLEMENT TO BENEFITS

§ 10.125 How does OWCP determine entitlement to benefits?

(a) In reaching any decision with respect to FECA coverage or entitlement, OWCP considers the claim presented by the claimant, the report by the employer, and the results of such investigation as OWCP may deem necessary.

(b) OWCP claims staff apply the law, the regulations, and its procedures to the facts as reported or obtained upon investigation. They also apply decisions of the Employees' Compensation

Appeals Board and administrative decisions of OWCP as set forth in FECA Program Memoranda.

§ 10.126 What does the decision contain?

The decision shall contain findings of fact and a statement of reasons. It is accompanied by information about the claimant's appeal rights, which may include the right to a hearing, a reconsideration, and/or a review by the Employees' Compensation Appeals Board. (See subpart G of this part.)

§ 10.127 To whom is the decision sent?

A copy of the decision shall be mailed to the employee's last known address. If the employee has a designated representative before OWCP, a copy of the decision will also be mailed to the representative. Notification to either the employee or the representative will be considered notification to both. A copy of the decision will also be sent to the employer.

Subpart C—Continuation of Pay

§ 10.200 What is continuation of pay?

(a) For most employees who sustain a traumatic injury, the FECA provides that the employer must continue the employee's regular pay during any periods of resulting disability, up to a maximum of 45 calendar days. This is called continuation of pay, or COP. The employer, not OWCP, pays COP. Unlike wage loss benefits, COP is subject to taxes and all other payroll deductions that are made from regular income.

(b) The employer must continue the pay of an employee who is eligible for COP, and may not require the employee to use his or her own sick or annual leave, unless the provisions of §§ 10.200(c), 10.220, or § 10.222 apply. However, while continuing the employee's pay, the employer may controvert the employee's COP entitlement pending a final determination by OWCP. OWCP has the exclusive authority to determine questions of entitlement and all other issues relating to COP.

(c) The FECA excludes certain persons from eligibility for COP. COP cannot be authorized for members of these excluded groups, which include but are not limited to: persons rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay; volunteers (for instance, in the Civil Air Patrol and Peace Corps); Job Corps and Youth Conservation Corps enrollees; individuals in work-study programs, and grand or petit jurors (unless otherwise Federal employees).

ELIGIBILITY FOR COP

§ 10.205 What conditions must be met to receive COP?

(a) To be eligible for COP, a person must:

(1) Have a ''traumatic injury'' as defined at § 10.5(ee) which is job-related and the cause of the disability, and/or the cause of lost time due to the need for medical examination and treatment;

(2) File Form CA–1 within 30 days of the date of the injury (but if that form is not available, using another form would not alone preclude receipt); and

(3) Begin losing time from work due to the traumatic injury within 45 days of the injury.

(b) OWCP may find that the employee is not entitled to COP for other reasons consistent with the statute (see § 10.220).

§ 10.206 May an employee who uses leave after an injury later decide to use COP instead?

On Form CA–1, an employee may elect to use accumulated sick or annual leave, or leave advanced by the agency, instead of electing COP. The employee can change the election between leave and COP for prospective periods at any point while eligibility for COP remains. The employee may also change the election for past periods and request COP in lieu of leave already taken for the same period. In either situation, the following provisions apply:

(a) The request must be made to the employer within one year of the date the leave was used or the date of the written approval of the claim by OWCP (if written approval is issued), whichever is later.

(b) Where the employee is otherwise eligible, the agency shall restore leave taken in lieu of any of the 45 COP days.

Where any of the 45 COP days remain unused, the agency shall continue pay prospectively.

(c) The use of leave may not be used to delay or extend the 45-day COP period or to otherwise affect the time limitation as provided by 5 U.S.C. 8117. Therefore, any leave used during the period of eligibility counts towards the 45-day maximum entitlement to COP.

§ 10.207 May an employee who returns to work, then stops work again due to the effects of the injury, receive COP?

If the employee recovers from disability and returns to work, then becomes disabled again and stops work, the employer shall pay any of the 45 days of entitlement to COP not used during the initial period of disability where:

(a) The employee completes Form CA–2a and elects to receive regular pay;

(b) OWCP did not deny the original claim for disability;

(c) The disability recurs and the employee stops work within 45 days of the time the employee first returned to work following the initial period of disability; and

(d) Pay has not been continued for the entire 45 days.

RESPONSIBILITIES

§ 10.210 What are the employee's responsibilities in COP cases?

An employee who sustains a traumatic injury which he or she considers disabling, or someone authorized to act on his or her behalf, must take the following actions to ensure continuing eligibility for COP. The employee must:

(a) Complete and submit Form CA–1 to the employing agency as soon as possible, but no later than 30 days from the date the traumatic injury occurred.

(b) Ensure that medical evidence supporting disability resulting from the claimed traumatic injury, including a statement as to when the employee can return to his or her date of injury job, is provided to the employer within 10 calendar days after filing the claim for COP.

(c) Ensure that relevant medical evidence is submitted to OWCP, and cooperate with OWCP in developing the claim.

(d) Ensure that the treating physician specifies work limitations and provides them to the employer and/or representatives of OWCP.

(e) Provide to the treating physician a description of any specific alternative positions offered the employee, and ensure that the treating physician responds promptly to the employer and/or OWCP, with an opinion as to whether and how soon the employee could perform that or any other specific position.

§ 10.211 What are the employer's responsibilities in COP cases?

Once the employer learns of a traumatic injury sustained by an employee, it shall:

(a) Provide a Form CA–1 and Form CA–16 to authorize medical care in accordance with § 10.300. Failure to do so may mean that OWCP will not uphold any termination of COP by the employer.

(b) Advise the employee of the right to receive COP, and the need to elect among COP, annual or sick leave or leave without pay, for any period of disability.

(c) Inform the employee of any decision to controvert COP and/or terminate pay, and the basis for doing so.

(d) Complete Form CA–1 and transmit it, along with all other available pertinent information, (including the basis for any controversion), to OWCP within 10 working days after receiving the completed form from the employee.

CALCULATION OF COP

§ 10.215 How does OWCP compute the number of days of COP used?

COP is payable for a maximum of 45 calendar days, and every day used is counted toward this maximum. The following rules apply:

(a) Time lost on the day or shift of the injury does not count toward COP. (Instead, the agency must keep the employee in a pay status for that period);

(b) The first COP day is the first day disability begins following the date of injury (providing it is within the 45 days following the date of injury), except where the injury occurs before the

beginning of the work day or shift, in which case the date of injury is charged to COP;

(c) Any part of a day or shift (except for the day of the injury) counts as a full day toward the 45 calendar day total;

(d) Regular days off are included if COP has been used on the regular work days immediately preceding or following the regular day(s) off, and medical evidence supports disability; and

(e) Leave used during a period when COP is otherwise payable is counted toward the 45-day COP maximum as if the employee had been in a COP status.

(f) For employees with part-time or intermittent schedules, all calendar days on which medical evidence indicates disability are counted as COP days, regardless of whether the employee was or would have been scheduled to work on those days. The rate at which COP is paid for these employees is calculated according to §10.216(b).

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

§10.216 How is the pay rate for COP calculated?

The employer shall calculate COP using the period of time and the weekly pay rate.

(a) The pay rate for COP purposes is equal to the employee's regular ''weekly'' pay (the average of the weekly pay over the preceding 52 weeks).

(1) The pay rate excludes overtime pay, but includes other applicable extra pay except to the extent prohibited by law.

(2) Changes in pay or salary (for example, promotion, demotion, within-grade increases, termination of a temporary detail, etc.) which would have otherwise occurred during the 45-day period are to be reflected in the weekly pay determination.

(b) The weekly pay for COP purposes is determined according to the following formulas:

(1) For full or part-time workers (permanent or temporary) who work the same number of hours each week of the year (or of the appointment), the weekly pay rate is the hourly pay rate (A) in effect on the date of injury multiplied by (×) the number of hours worked each week (B): A × B = Weekly Pay Rate.

(2) For part-time workers (permanent or temporary) who do not work the same number of hours each week, but who do work each week of the year (or period of appointment), the weekly pay rate is an average of the weekly earnings, established by dividing (÷) the total earnings (excluding overtime) from the year immediately preceding the injury (A) by the number of weeks (or partial weeks) worked in that year (B): A ÷ B = Weekly Pay Rate.

(3) For intermittent and seasonal workers, whether permanent or temporary, who do not work either the same number of hours or every week of the year (or period of appointment), the weekly pay rate is the average weekly earnings established by dividing (÷) the total earnings during the full 12-month period immediately preceding the date of injury (excluding overtime) (A), by the number of weeks (or partial weeks) worked during that year (B) (that is, A ÷ B); or 150 times the average daily wage earned in the employment during the days employed within the full year immediately preceding the date of injury divided by 52 weeks, whichever is greater.

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

§10.217 Is COP charged if the employee continues to work, but in a different job that pays less?

If the employee cannot perform the duties of his or her regular position, but instead works in another job with different duties with no loss in pay, then COP is not chargeable. COP must be paid and the days counted against the 45 days authorized by law whenever an actual reduction of pay results from the injury, including a reduction of pay for the employee's normal administrative workweek that results from a change or diminution in his or her duties following an injury. However, this does not include a reduction of pay that is due solely to an employer being prohibited by law from paying extra pay to an employee for work he or she does not actually perform.

CONTROVERSION AND TERMINATION OF COP

§ 10.220 When is an employer not required to pay COP?

An employer shall continue the regular pay of an eligible employee without a break in time for up to 45 calendar days, except when, and only when:

(a) The disability was not caused by a traumatic injury;

(b) The employee is not a citizen of the United States or Canada;

(c) No written claim was filed within 30 days from the date of injury;

(d) The injury was not reported until after employment has been terminated;

(e) The injury occurred off the employing agency's premises and was otherwise not within the performance of official duties;

(f) The injury was caused by the employee's willful misconduct, intent to injure or kill himself or herself or another person, or was proximately caused by intoxication by alcohol or illegal drugs; or

(g) Work did not stop until more than 45 days following the injury.

[63 FR 65306, Nov. 25, 1998; 64 FR 12684, Mar. 12, 1999]

§ 10.221 How is a claim for COP controverted?

When the employer stops an employee's pay for one of the reasons cited in § 10.220, the employer must controvert the claim for COP on Form CA–1, explaining in detail the basis for the refusal. The final determination on entitlement to COP always rests with OWCP.

§ 10.222 When may an employer terminate COP which has already begun?

(a) Where the employer has continued the pay of the employee, it may be stopped only when at least one of the following circumstances is present:

(1) Medical evidence which on its face supports disability due to a work-related injury is not received within 10 calendar days after the claim is submitted (unless the employer's own investigation shows disability to exist). Where the medical evidence is later provided, however, COP shall be reinstated retroactive to the date of termination;

(2) The medical evidence from the treating physician shows that the employee is not disabled from his or her regular position;

(3) Medical evidence from the treating physician shows that the employee is not totally disabled, and the employee refuses a written offer of a suitable alternative position which is approved by the attending physician. If OWCP later determines that the position was not suitable, OWCP will direct the employer to grant the employee COP retroactive to the termination date.

(4) The employee returns to work with no loss of pay;

(5) The employee's period of employment expires or employment is otherwise terminated (as established prior to the date of injury);

(6) OWCP directs the employer to stop COP; and/or

(7) COP has been paid for 45 calendar days.

(b) An employer may not interrupt or stop COP to which the employee is otherwise entitled because of a disciplinary action, unless a preliminary notice was issued to the employee before the date of injury and the action becomes final or otherwise takes effect during the COP period.

(c) An employer cannot otherwise stop COP unless it does so for one of the reasons found in this section or § 10.220. Where an employer stops COP, it must file a controversion with OWCP, setting forth the basis on which it terminated COP, no later than the effective date of the termination.

§ 10.223 Are there other circumstances under which OWCP will not authorize payment of COP?

When OWCP finds that an employee or his or her representative refuses or obstructs a medical examination required by OWCP, the right to COP is suspended until the refusal or obstruction ceases. COP already paid or payable for the period of suspension is forfeited. If already paid, the COP may be charged to annual or sick leave or considered an overpayment of pay consistent with 5 U.S.C. 5584.

§ 10.224 What happens if OWCP finds that the employee is not entitled to COP after it has been paid?

Where OWCP finds that the employee is not entitled to COP after it has been paid, the employee may chose to have the time charged to annual or sick leave, or considered an overpayment of pay under 5 U.S.C. 5584. The employer must correct any deficiencies in COP as directed by OWCP.

Subpart D—Medical and Related Benefits

EMERGENCY MEDICAL CARE

§ 10.300 What are the basic rules for authorizing emergency medical care?

(a) When an employee sustains a work-related traumatic injury that requires medical examination, medical treatment, or both, the employer shall authorize such examination and/or treatment by issuing a Form CA–16. This form may be used for occupational disease or illness only if the employer has obtained prior permission from OWCP.

(b) The employer shall issue Form CA–16 within four hours of the claimed injury. If the employer gives verbal authorization for such care, he or she should issue a Form CA–16 within 48 hours. The employer is not required to issue a Form CA–16 more than one week after the occurrence of the claimed injury. The employer may not authorize examination or medical or other treatment in any case that OWCP has disallowed.

(c) Form CA–16 must contain the full name and address of the qualified physician or qualified medical facility authorized to provide service. The authorizing official must sign and date the form and must state his or her title. Form CA–16 authorizes treatment for 60 days from the date of issuance, unless OWCP terminates the authorization sooner.

(d) The employer should advise the employee of the right to his or her initial choice of physician. The employer shall allow the employee to select a qualified physician, after advising him or her of those physicians excluded under subpart I of this part. The physician may be in private practice, including a health maintenance organization (HMO), or employed by a Federal agency such as the Department of the Army, Navy, Air Force, or Veterans Affairs. Any qualified physician may provide initial treatment of a work-related injury in an emergency. See also §10.825(b).

§ 10.301 May the physician designated on Form CA–16 refer the employee to another medical specialist or medical facility?

The physician designated on Form CA–16 may refer the employee for further examination, testing, or medical care. OWCP will pay this physician or facility's bill on the authority of Form CA–16. The employer should not issue a second Form CA–16.

§ 10.302 Should the employer authorize medical care if he or she doubts that the injury occurred, or that it is work-related?

If the employer doubts that the injury occurred, or that it is work-related, he or she should authorize medical care by completing Form CA–16 and checking block 6B of the form. If the medical and factual evidence sent to OWCP shows that the condition treated is not work-related, OWCP will notify the employee, the employer, and the physician or hospital that OWCP will not authorize payment for any further treatment.

§ 10.303 Should the employer use a Form CA–16 to authorize medical testing when an employee is exposed to a workplace hazard just once?

(a) Simple exposure to a workplace hazard, such as an infectious agent, does not constitute a work-related injury entitling an employee to medical treatment under the FECA. The employer therefore should not use a Form CA–16 to authorize medical testing for an employee who has merely been exposed to a workplace hazard, unless the employee has sustained an identifiable injury or medical condition as a result of that exposure. OWCP will authorize preventive treatment only under certain well-defined circumstances (see §10.313).

(b) Employers may be required under other statutes or regulations to provide their employees with medical testing and/or other services in situations described in paragraph (a) of this section. For example, regulations issued by the Occupational Safety and Health Administration at 29 CFR chapter XVII require employers to provide their employees with medical consultations and/or examinations when they either exhibit symptoms consistent with exposure to a workplace hazard, or when an identifiable event such as a spill, leak or explosion occurs and results in the likelihood of exposure to a workplace hazard. In addition, 5 U.S.C. 7901 authorizes employers to establish health programs whose staff can perform tests for workplace hazards, counsel employees for exposure or feared exposure to such hazards, and provide health care screening and other associated services.

§ 10.304 Are there any exceptions to these procedures for obtaining medical care?

In cases involving emergencies or unusual circumstances, OWCP may authorize treatment in a manner other than as stated in this subpart.

MEDICAL TREATMENT AND RELATED ISSUES

§ 10.310 What are the basic rules for obtaining medical care?

(a) The employee is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury. The employee need not be disabled to receive such treatment. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the work-related injury, the employee should consult OWCP prior to obtaining it.

(b) Any qualified physician or qualified hospital may provide such services, appliances and supplies. A qualified provider of medical support services may also furnish appropriate services, appliances, and supplies. OWCP may apply a test of cost-effectiveness to appliances and supplies. With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available.

§ 10.311 What are the special rules for the services of chiropractors?

(a) The services of chiropractors that may be reimbursed are limited by the FECA to treatment to correct a spinal subluxation. The costs of physical and related laboratory tests performed by or required by a chiropractor to diagnose such a subluxation are also payable.

(b) In accordance with 5 U.S.C. 8101(3), a diagnosis of spinal ''subluxation as demonstrated by X-ray to exist'' must appear in the chiropractor's report before OWCP can consider payment of a chiropractor's bill.

(c) A chiropractor may interpret his or her x-rays to the same extent as any other physician. To be given any weight, the medical report must state that x-rays support the finding of spinal subluxation. OWCP will not necessarily require submittal of the x-ray, or a report of the x-ray, but the report must be available for submittal on request.

(d) A chiropractor may also provide services in the nature of physical therapy under the direction of a qualified physician.

§ 10.312 What are the special rules for the services of clinical psychologists?

A clinical psychologist may serve as a physician only within the scope of his or her practice as defined by State law. Therefore, a clinical psychologist may not serve as a physician for conditions that include a physical component unless the applicable State law allows clinical psychologists to treat physical conditions. A clinical psychologist may also perform testing, evaluation and other services under the direction of a qualified physician.

§ 10.313 Will OWCP pay for preventive treatment?

The FECA does not authorize payment for preventive measures such as vaccines and inoculations, and in general, preventive treatment may be a responsibility of the employing agency under the provisions of 5 U.S.C. 7901

(see §10.303). However, OWCP can authorize treatment for the following conditions, even though such treatment is designed, in part, to prevent further injury:

(a) Complications of preventive measures which are provided or sponsored by the agency, such as an adverse reaction to prophylactic immunization.

(b) Actual or probable exposure to a known contaminant due to an injury, thereby requiring disease-specific measures against infection. Examples include the provision of tetanus antitoxin or booster toxoid injections for puncture wounds; administration of rabies vaccine for a bite from a rabid or potentially rabid animal; or appropriate measures where exposure to human immunodeficiency virus (HIV) has occurred.

(c) Conversion of tuberculin reaction from negative to positive following exposure to tuberculosis in the performance of duty. In this situation, the appropriate therapy may be authorized.

(d) Where injury to one eye has resulted in loss of vision, periodic examination of the uninjured eye to detect possible sympathetic involvement of the uninjured eye at an early stage.

§ 10.314 Will OWCP pay for the services of an attendant?

Yes, OWCP will pay for the services of an attendant up to a maximum of $1,500 per month, where the need for such services has been medically documented. In the exercise of the discretion afforded by 5 U.S.C. 8111(a), the Director has determined that, except where payments were being made prior to January 4, 1999, direct payments to the claimant to cover such services will no longer be made. Rather, the cost of providing attendant services will be paid under section 8103 of the Act, and medical bills for these services will be considered under §10.801. This decision is based on the following factors:

(a) The additional payments authorized under section 8111(a) should not be necessary since OWCP will authorize payment for personal care services under 5 U.S.C. 8103, whether or not such care includes medical services, so long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual.

(b) A home health aide, licensed practical nurse, or similarly trained individual is better able to provide quality personal care services, including assistance in feeding, bathing, and using the toilet. In the past, provision of supplemental compensation directly to injured employees may have encouraged family members to take on these responsibilities even though they may not have been trained to provide such services. By paying for the services under section 8103, OWCP can better determine whether the services provided are necessary and/or adequate to meet the needs of the injured employee. In addition, a system requiring the personal care provider to submit a bill to OWCP, where the amount billed will be subject to OWCP's fee schedule, will result in greater fiscal accountability.

§ 10.315 Will OWCP pay for transportation to obtain medical treatment?

The employee is entitled to reimbursement of reasonable and necessary expenses, including transportation needed to obtain authorized medical services, appliances or supplies. To determine what is a reasonable distance to travel, OWCP will consider the availability of services, the employee's condition, and the means of transportation. Generally, 25 miles from the place of injury, the work site, or the employee's home, is considered a reasonable distance to travel. The standard form designated for Federal employees to claim travel expenses should be used to seek reimbursement under this section.

§ 10.316 After selecting a treating physician, may an employee choose to be treated by another physician instead?

(a) When the physician originally selected to provide treatment for a work-related injury refers the employee to a specialist for further medical care, the employee need not consult OWCP for approval. In all other instances, however, the employee must submit a written request to OWCP with his or her

reasons for desiring a change of physician.

(b) OWCP will approve the request if it determines that the reasons submitted are sufficient. Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating conditions like the work-related one, or the need for a new physician when an employee has moved. The employer may not authorize a change of physicians.

DIRECTED MEDICAL EXAMINATIONS

§ 10.320 Can OWCP require an employee to be examined by another physician?

OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician as often and at such times and places as OWCP considers reasonably necessary. The employee may have a qualified physician, paid by him or her, present at such examination. However, the employee is not entitled to have anyone else present at the examination unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed. Also, OWCP may send a case file for second opinion review where actual examination is not needed, or where the employee is deceased.

§ 10.321 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

(a) If one medical opinion holds more probative value, OWCP will base its determination of entitlement on that medical conclusion (see § 10.502). A difference in medical opinion sufficient to be considered a conflict occurs when two reports of virtually equal weight and rationale reach opposing conclusions (*see James P. Roberts, 31 ECAB 1010 (1980)*).

(b) If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser or consultant, OWCP shall appoint a third physician to make an examination (see § 10.502). This is called a referee examination. OWCP will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case. The employee is not entitled to have anyone present at the examination unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed. Also, a case file may be sent for referee medical review where there is no need for an actual examination, or where the employee is deceased.

§ 10.322 Who pays for second opinion and referee examinations?

OWCP will pay second opinion and referee medical specialists directly. OWCP will reimburse the employee all necessary and reasonable expenses incident to such an examination, including transportation costs and actual wages lost for the time needed to submit to an examination required by OWCP.

§ 10.323 What are the penalties for failing to report for or obstructing a second opinion or referee examination?

If an employee refuses to submit to or in any way obstructs an examination required by OWCP, his or her right to compensation under the FECA is suspended until such refusal or obstruction stops. The action of the employee's representative is considered to be the action of the employee for purposes of this section. The employee will forfeit compensation otherwise paid or payable under the FECA for the period of the refusal or obstruction, and any compensation already paid for that period will be declared an overpayment and will be subject to recovery pursuant to 5 U.S.C. 8129.

§ 10.324 May an employer require an employee to undergo a physical examination in connection with a work-related injury?

The employer may have authority independent of the FECA to require the employee to undergo a medical examination to determine whether he or she meets the medical requirements of the position held or can perform the duties of that position. Nothing in the FECA

or in this part affects such authority. However, no agency-required examination or related activity shall interfere with the employee's initial choice of physician or the provision of any authorized examination or treatment, including the issuance of Form CA–16.

MEDICAL REPORTS

§ 10.330 What are the requirements for medical reports?

In all cases reported to OWCP, a medical report from the attending physician is required. This report should include:

(a) Dates of examination and treatment;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Diagnosis;

(f) Course of treatment;

(g) A description of any other conditions found but not due to the claimed injury;

(h) The treatment given or recommended for the claimed injury;

(i) The physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;

(j) The extent of disability affecting the employee's ability to work due to the injury;

(k) The prognosis for recovery; and

(l) All other material findings.

§ 10.331 How and when should the medical report be submitted?

(a) Form CA–16 may be used for the initial medical report, while Form CA–20 may be used for the initial report and for subsequent reports, including where continued compensation is claimed. Use of medical report forms is not required, however. The report may also be made in narrative form on the physician's letterhead stationery. The report should bear the physician's signature or signature stamp. OWCP may require an original signature on the report.

(b) The report shall be submitted directly to OWCP as soon as possible after medical examination or treatment is received, either by the employee or the physician. (See also § 10.210.) The employer may request a copy of the report from OWCP. The employer should use Form CA–17 to obtain interim reports concerning the duty status of an employee with a disabling injury.

[63 FR 65306, Nov. 25, 1998; 63 FR 71202, Dec. 23, 1998]

§ 10.332 What additional medical information will OWCP require to support continuing payment of benefits?

In all cases of serious injury or disease, especially those requiring hospital treatment or prolonged care, OWCP will request detailed narrative reports from the attending physician at periodic intervals. The physician will be asked to describe continuing medical treatment for the condition accepted by OWCP, a prognosis, a description of work limitations, if any, and the physician's opinion as to the continuing causal relationship between the employee's condition and factors of his or her Federal employment.

§ 10.333 What additional medical information will OWCP require to support a claim for a schedule award?

To support a claim for a schedule award, a medical report must contain accurate measurements of the function of the organ or member, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. These measurements may include: The actual degree of loss of active or passive motion or deformity; the amount of atrophy; the decrease, if any, in strength; the disturbance of sensation; and pain due to nerve impairment.

MEDICAL BILLS

§ 10.335 How are medical bills submitted?

Usually, medical providers submit bills directly to OWCP. The rules for submitting and paying bills are stated in subpart I of this part. An employee claiming reimbursement of medical expenses should submit an itemized bill as described in § 10.802.

§ 10.336 What are the time frames for submitting bills?

To be considered for payment, bills must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when OWCP first accepted the claim as compensable, whichever is later.

§ 10.337 If OWCP reimburses an employee only partially for a medical expense, must the provider refund the balance of the amount paid to the employee?

(a) The OWCP fee schedule sets maximum limits on the amounts payable for many services (see § 10.805). The employee may be only partially reimbursed for medical expenses because the amount he or she paid to the medical provider for a service exceeds the maximum allowable charge set by the OWCP fee schedule.

(b) If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider may request reconsideration of the fee determination as set forth in § 10.812.

(c) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may make reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

Subpart E—Compensation and Related Benefits

COMPENSATION FOR DISABILITY AND IMPAIRMENT

§ 10.400 What is total disability?

(a) Permanent total disability is presumed to result from the loss of use of both hands, both arms, both feet, or both legs, or the loss of sight of both eyes. However, the presumption of permanent total disability as a result of such loss may be rebutted by evidence to the contrary, such as evidence of continued ability to work and to earn wages despite the loss.

(b) Temporary total disability is defined as the inability to return to the position held at the time of injury or earn equivalent wages, or to perform other gainful employment, due to the work-related injury. Except as presumed under paragraph (a) of this section, an employee's disability status is always considered temporary pending return to work.

§ 10.401 When and how is compensation for total disability paid?

(a) Compensation is payable when the employee starts to lose pay if the injury causes permanent disability or if pay loss continues for more than 14 calendar days. Otherwise, compensation is payable on the fourth day after pay stops. Compensation may not be paid while an injured employee is in a continuation of pay status or receives pay for leave.

(b) Compensation for total disability is payable at the rate of 66⅔ percent of the pay rate if the employee has no dependents, or 75 percent of the pay rate if the employee has at least one dependent. (''Dependents'' are defined at 5 U.S.C. 8110(a).)

§ 10.402 What is partial disability?

An injured employee who cannot return to the position held at the time of injury (or earn equivalent wages) due to the work-related injury, but who is not totally disabled for all gainful employment, is considered to be partially disabled.

§ 10.403 When and how is compensation for partial disability paid?

(a) 5 U.S.C. 8115 outlines how compensation for partial disability is determined. If the employee has actual earnings which fairly and reasonably represent his or her wage-earning capacity, those earnings may form the basis for payment of compensation for partial disability. (See §§ 10.500 through 10.520 concerning return to work.) If the employee's actual earnings do not fairly and reasonably represent his or her wage-earning capacity, or if the employee has no actual earnings,

OWCP uses the factors stated in 5 U.S.C. 8115 to select a position which represents his or her wage-earning capacity. However, OWCP will not secure employment for the employee in the position selected for establishing a wage-earning capacity.

(b) Compensation for partial disability is payable as a percentage of the difference between the employee's pay rate for compensation purposes and the employee's wage-earning capacity. The percentage is 66⅔ percent of this difference if the employee has no dependents, or 75 percent of this difference if the employee has at least one dependent.

(c) The formula which OWCP uses to compute the compensation payable for partial disability employs the following terms: Pay rate for compensation purposes, which is defined in §10.5(s) of this part; current pay rate, which means the salary or wages for the job held at the time of injury at the time of the determination; and earnings, which means the employee's actual earnings, or the salary or pay rate of the position selected by OWCP as representing the employee's wage-earning capacity.

(d) The employee's wage-earning capacity in terms of percentage is computed by dividing the employee's earnings by the current pay rate. The comparison of earnings and ''current'' pay rate for the job held at the time of injury need not be made as of the beginning of partial disability. OWCP may use any convenient date for making the comparison as long as both wage rates are in effect on the date used for comparison.

(e) The employee's wage-earning capacity in terms of dollars is computed by first multiplying the pay rate for compensation purposes by the percentage of wage-earning capacity. The resulting dollar amount is then subtracted from the pay rate for compensation purposes to obtain the employee's loss of wage-earning capacity.

§10.404 When and how is compensation for a schedule impairment paid?

Compensation is provided for specified periods of time for the permanent loss or loss of use of certain members, organs and functions of the body. Such loss or loss of use is known as permanent impairment. Compensation for proportionate periods of time is payable for partial loss or loss of use of each member, organ or function. OWCP evaluates the degree of impairment to schedule members, organs and functions as defined in 5 U.S.C. 8107 according to the standards set forth in the specified (by OWCP) edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*.

(a) 5 U.S.C. 8107(c) provides a list of schedule members. Pursuant to the authority provided by 5 U.S.C. 8107(c)(22), the Secretary has added the following organs to the compensation schedule for injuries that were sustained on or after September 7, 1974:

Member	Weeks
Breast (one)	52
Kidney (one)	156
Larynx	160
Lung (one)	156
Penis	205
Testicle (one)	52
Tongue	160
Ovary (one)	52
Uterus/cervix and vulva/vagina	205

(b) Compensation for schedule awards is payable at 66⅔ percent of the employee's pay, or 75 percent of the pay when the employee has at least one dependent.

(c) The period of compensation payable under 5 U.S.C. 8107(c) shall be reduced by the period of compensation paid or payable under the schedule for an earlier injury if:

(1) Compensation in both cases is for impairment of the same member or function or different parts of the same member or function, or for disfigurement; and

(2) OWCP finds that compensation payable for the later impairment in whole or in part would duplicate the compensation payable for the pre-existing impairment.

(d) Compensation not to exceed $3,500 may be paid for serious disfigurement of the face, head or neck which is likely to handicap a person in securing or maintaining employment.

§ 10.405 Who is considered a dependent in a claim based on disability or impairment?

(a) Dependents include a wife or husband; an unmarried child under 18 years of age; an unmarried child over 18 who is incapable of self-support; a student, until he or she reaches 23 years of age or completes four years of school beyond the high school level; or a wholly dependent parent.

(b) Augmented compensation payable for an unmarried child, which would otherwise terminate when the child reached the age of 18, may be continued while the child is a student as defined in 5 U.S.C. 8101(17).

§ 10.406 What are the maximum and minimum rates of compensation in disability cases?

(a) Compensation for total or partial disability may not exceed 75 percent of the basic monthly pay of the highest step of grade 15 of the General Schedule. (Basic monthly pay does not include locality adjustments.) However, this limit does not apply to disability sustained in the performance of duty which was due to an assault which occurred during an attempted assassination of a Federal official described under 10 U.S.C. 351(a) or 1751(a).

(b) Compensation for total disability may not be less than 75 percent of the basic monthly pay of the first step of grade 2 of the General Schedule or actual pay, whichever is less. (Basic monthly pay does not include locality adjustments.)

COMPENSATION FOR DEATH

§ 10.410 Who is entitled to compensation in case of death, and what are the rates of compensation payable in death cases?

(a) If there is no child entitled to compensation, the employee's surviving spouse will receive compensation equal to 50 percent of the employee's monthly pay until death or remarriage before reaching age 55. Upon remarriage, the surviving spouse will be paid a lump sum equal to 24 times the monthly compensation payment (excluding compensation payable on account of another individual) to which the surviving spouse was entitled immediately before the remarriage. If remarriage occurs at age 55 or older, the lump-sum payment will not be paid and compensation will continue until death.

(b) If there is a child entitled to compensation, the compensation for the surviving spouse will equal 45 percent of the employee's monthly pay plus 15 percent for each child, but the total percentage may not exceed 75 percent.

(c) If there is a child entitled to compensation and no surviving spouse, compensation for one child will equal 40 percent of the employee's monthly pay. Fifteen percent will be awarded for each additional child, not to exceed 75 percent, the total amount to be shared equally among all children.

(d) If there is no child or surviving spouse entitled to compensation, the parents will receive compensation equal to 25 percent of the employee's monthly pay if one parent was wholly dependent on the employee at the time of death and the other was not dependent to any extent, or 20 percent each if both were wholly dependent on the employee, or a proportionate amount in the discretion of the Director if one or both were partially dependent on the employee. If there is a child or surviving spouse entitled to compensation, the parents will receive so much of the compensation described in the preceding sentence as, when added to the total percentages payable to the surviving spouse and children, will not exceed a total of 75 percent of the employee's monthly pay.

(e) If there is no child, surviving spouse or dependent parent entitled to compensation, the brothers, sisters, grandparents and grandchildren will receive compensation equal to 20 percent of the employee's monthly pay to such dependent if one was wholly dependent on the employee at the time of death; or 30 percent if more than one was wholly dependent, divided among such dependents equally; or 10 percent if no one was wholly dependent but one or more was partly dependent, divided among such dependents equally. If there is a child, surviving spouse or dependent parent entitled to compensation, the brothers, sisters, grandparents and grandchildren will receive so much of the compensation described in the preceding sentence as, when

added to the total percentages payable to the children, surviving spouse and dependent parents, will not exceed a total of 75 percent of the employee's monthly pay.

(f) A child, brother, sister or grandchild may be entitled to receive death benefits until death, marriage, or reaching age 18. Regarding entitlement after reaching age 18, refer to §10.417 of these regulations.

§10.411 What are the maximum and minimum rates of compensation in death cases?

(a) Compensation for death may not exceed the employee's pay or 75 percent of the basic monthly pay of the highest step of grade 15 of the General Schedule, except that compensation may exceed the employee's basic monthly pay if such excess is created by authorized cost-of-living increases. (Basic monthly pay does not include locality adjustments.) However, the maximum limit does not apply when the death occurred during an assassination of a Federal official described under 18 U.S.C. 351(a) or 18 U.S.C. 1751(a).

(b) Compensation for death is computed on a minimum pay rate equal to the basic monthly pay of an employee at the first step of grade 2 of the General Schedule. (Basic monthly pay does not include locality adjustments.)

§10.412 Will OWCP pay the costs of burial and transportation of the remains?

In a case accepted for death benefits, OWCP will pay up to $800 for funeral and burial expenses. When an employee's home is within the United States and the employee dies outside the United States, or away from home or the official duty station, an additional amount may be paid for transporting the remains to the employee's home. An additional amount of $200 is paid to the personal representative of the decedent for reimbursement of the costs of terminating the decedent's status as an employee of the United States.

§10.413 If a person dies while receiving a schedule award, to whom is the balance of the schedule award payable?

The circumstances under which the balance of a schedule award may be paid to an employee's survivors are described in 5 U.S.C. 8109. Therefore, if there is no surviving spouse or child, OWCP will pay benefits as follows:

(a) To the parent, or parents, wholly dependent for support on the decedent in equal shares with any wholly dependent brother, sister, grandparent or grandchild;

(b) To the parent, or parents, partially dependent for support on the decedent in equal shares when there are no wholly dependent brothers, sisters, grandparents or grandchildren (or other wholly dependent parent); and

(c) To the parent, or parents, partially dependent upon the decedent, 25 percent of the amount payable, shared equally, and the remaining 75 percent to any wholly dependent brother, sister, grandparent or grandchild (or wholly dependent parent), shared equally.

§10.414 What reports of dependents are needed in death cases?

If a beneficiary is receiving compensation benefits on account of an employee's death, OWCP will ask him or her to complete a report once each year on Form CA–12. The report requires the beneficiary to note changes in marital status and dependents. If the beneficiary fails to submit the form (or an equivalent written statement) within 30 days of the date of request, OWCP shall suspend compensation until the requested form or equivalent written statement is received. The suspension will include compensation payable for or on behalf of another person (for example, compensation payable to a widow on behalf of a child). When the form or statement is received, compensation will be reinstated at the appropriate rate retroactive to the date of suspension, provided the beneficiary is entitled to such compensation.

§10.415 What must a beneficiary do if the number of beneficiaries decreases?

The circumstances under which compensation on account of death shall be terminated are described in 5 U.S.C. 8133(b). A beneficiary in a claim for death benefits should promptly notify OWCP of any event which would affect

his or her entitlement to continued compensation. The terms ''marriage'' and ''remarriage'' include common-law marriage as recognized and defined by State law in the State where the beneficiary resides. If a beneficiary, or someone acting on his or her behalf, receives a check which includes payment of compensation for any period after the date when entitlement ended, he or she must promptly return the check to OWCP.

§ 10.416 How does a change in the number of beneficiaries affect the amount of compensation paid to the other beneficiaries?

If compensation to a beneficiary is terminated, the amount of compensation payable to one or more of the remaining beneficiaries may be reapportioned. Similarly, the birth of a posthumous child may result in a reapportionment of the amount of compensation payable to other beneficiaries. The parent, or someone acting on the child's behalf, shall promptly notify OWCP of the birth and submit a copy of the birth certificate.

§ 10.417 What reports are needed when compensation payments continue for children over age 18?

(a) Compensation payable on behalf of a child, brother, sister, or grandchild, which would otherwise end when the person reaches 18 years of age, shall be continued if and for so long as he or she is not married and is either a student as defined in 5 U.S.C. 8101(17), or physically or mentally incapable of self-support.

(b) At least twice each year, OWCP will ask a beneficiary receiving compensation based on the student status of a dependent to provide proof of continuing entitlement to such compensation, including certification of school enrollment.

(c) Likewise, at least twice each year, OWCP will ask a beneficiary or legal guardian receiving compensation based on a dependent's physical or mental inability to support himself or herself to submit a medical report verifying that the dependent's medical condition persists and that it continues to preclude self-support.

ADJUSTMENTS TO COMPENSATION

§ 10.420 How are cost-of-living adjustments applied?

(a) In cases of disability, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where injury-related disability began more than one year prior to the date the cost-of-living adjustment took effect. The employee's use of continuation of pay as provided by 5 U.S.C. 8118, or of sick or annual leave, during any part of the period of disability does not affect the computation of the one-year period.

(b) Where an injury does not result in disability but compensation is payable for permanent impairment of a covered member, organ or function of the body, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where the award for such impairment began more than one year prior to the date the cost-of-living adjustment took effect.

(c) In cases of recurrence of disability, where the pay rate for compensation purposes is the pay rate at the time disability recurs, a beneficiary is eligible for cost-of-living adjustments under 5 U.S.C. 8146a where the effective date of that pay rate began more than one year prior to the date the cost-of living adjustment took effect.

(d) In cases of death, entitlement to cost-of-living adjustments under 5 U.S.C. 8146a begins with the first such adjustment occurring more than one year after the date of death. However, if the death was preceded by a period of injury-related disability, compensation payable to the survivors will be increased by the same percentages as the cost-of-living adjustments paid or payable to the deceased employee for the period of disability, as well as by subsequent cost-of-living adjustments to which the survivors would otherwise be entitled.

§ 10.421 May a beneficiary receive other kinds of payments from the Federal Government concurrently with compensation?

(a) 5 U.S.C. 8116(a) provides that a beneficiary may not receive wage-loss

compensation concurrently with a Federal retirement or survivor annuity. The beneficiary must elect the benefit that he or she wishes to receive, and the election, once made, is revocable.

(b) An employee may receive compensation concurrently with military retired pay, retirement pay, retainer pay or equivalent pay for service in the Armed Forces or other uniformed services, subject to the reduction of such pay in accordance with 5 U.S.C. 5532(b).

(c) An employee may not receive compensation for total disability concurrently with severance pay or separation pay. However, an employee may concurrently receive compensation for partial disability or permanent impairment to a schedule member, organ or function with severance pay or separation pay.

(d) Pursuant to 5 U.S.C. 8116(d), a beneficiary may receive compensation under the FECA for either the death or disability of an employee concurrently with benefits under title II of the Social Security Act on account of the age or death of such employee. However, this provision of the FECA also requires OWCP to reduce the amount of any such compensation by the amount of any Social Security Act benefits that are attributable to the Federal service of the employee.

(e) To determine the employee's entitlement to compensation, OWCP may require an employee to submit an affidavit or statement as to the receipt of any Federally funded or Federally assisted benefits. If an employee fails to submit such affidavit or statement within 30 days of the date of the request, his or her right to compensation shall be suspended until such time as the requested affidavit or statement is received. At that time compensation will be reinstated retroactive to the date of suspension provided the employee is entitled to such compensation.

§ 10.422 May compensation payments be issued in a lump sum?

(a) In exercise of the discretion afforded under 5 U.S.C. 8135(a), OWCP has determined that lump-sum payments will not be made to persons entitled to wage-loss benefits (that is, those payable under 5 U.S.C. 8105 and 8106). Therefore, when OWCP receives requests for lump-sum payments for wage-loss benefits, OWCP will not exercise further discretion in the matter. This determination is based on several factors, including:

(1) The purpose of the FECA, which is to replace lost wages;

(2) The prudence of providing wage-loss benefits on a regular, recurring basis; and

(3) The high cost of the long-term borrowing that is needed to pay out large lump sums.

(b) However, a lump-sum payment may be made to an employee entitled to a schedule award under 5 U.S.C. 8107 where OWCP determines that such a payment is in the employee's best interest. Lump-sum payments of schedule awards generally will be considered in the employee's best interest only where the employee does not rely upon compensation payments as a substitute for lost wages (that is, the employee is working or is receiving annuity payments). An employee possesses no absolute right to a lump-sum payment of benefits payable under 5 U.S.C. 8107.

(c) Lump-sum payments to surviving spouses are addressed in 5 U.S.C. 8135(b).

§ 10.423 May compensation payments be assigned to, or attached by, creditors?

(a) As a general rule, compensation and claims for compensation are exempt from the claims of private creditors. This rule does not apply to claims submitted by Federal agencies. Further, any attempt by a FECA beneficiary to assign his or her claim is null and void. However, pursuant to provisions of the Social Security Act, 42 U.S.C. 659, and regulations issued by the Office of Personnel Management (OPM) at 5 CFR part 581, FECA benefits, including survivor's benefits, may be garnished to collect overdue alimony and child support payments.

(b) Garnishment for child support and alimony may be requested by providing a copy of the State agency or court order to the district office handling the FECA claim.

§ 10.424 May someone other than the beneficiary be designated to receive compensation payments?

A beneficiary may be incapable of managing or directing the management of his or her benefits because of a mental or physical disability, or because of legal incompetence, or because he or she is under 18 years of age. In this situation, absent the appointment of a guardian or other party to manage the financial affairs of the claimant by a court or administrative body authorized to do so, OWCP in its sole discretion may approve a person to serve as the representative payee for funds due the beneficiary.

§ 10.425 May compensation be claimed for periods of restorable leave?

The employee may claim compensation for periods of annual and sick leave which are restorable in accordance with the rules of the employing agency. Forms CA–7a and CA–7b are used for this purpose.

OVERPAYMENTS

§ 10.430 How does OWCP notify an individual of a payment made?

(a) In addition to providing narrative descriptions to recipients of benefits paid or payable, OWCP includes on each periodic check a clear indication of the period for which payment is being made. A form is sent to the recipient with each supplemental check which states the date and amount of the payment and the period for which payment is being made. For payments sent by electronic funds transfer (EFT), a notification of the date and amount of payment appears on the statement from the recipient's financial institution.

(b) By these means, OWCP puts the recipient on notice that a payment was made and the amount of the payment. If the amount received differs from the amount indicated on the written notice or bank statement, the recipient is responsible for notifying OWCP of the difference. Absent affirmative evidence to the contrary, the beneficiary will be presumed to have received the notice of payment, whether mailed or transmitted electronically.

§ 10.431 What does OWCP do when an overpayment is identified?

Before seeking to recover an overpayment or adjust benefits, OWCP will advise the beneficiary in writing that:

(a) The overpayment exists, and the amount of overpayment;

(b) A preliminary finding shows either that the individual was or was not at fault in the creation of the overpayment;

(c) He or she has the right to inspect and copy Government records relating to the overpayment; and

(d) He or she has the right to present evidence which challenges the fact or amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived.

§ 10.432 How can an individual present evidence to OWCP in response to a preliminary notice of an overpayment?

The individual may present this evidence to OWCP in writing or at a prerecoupment hearing. The evidence must be presented or the hearing requested within 30 days of the date of the written notice of overpayment. Failure to request the hearing within this 30-day time period shall constitute a waiver of that right.

§ 10.433 Under what circumstances can OWCP waive recovery of an overpayment?

(a) OWCP may consider waiving an overpayment only if the individual to whom it was made was not at fault in accepting or creating the overpayment. Each recipient of compensation benefits is responsible for taking all reasonable measures to ensure that payments he or she receives from OWCP are proper. The recipient must show good faith and exercise a high degree of care in reporting events which may affect entitlement to or the amount of benefits. A recipient who has done any of the following will be found to be at fault with respect to creating an overpayment:

(1) Made an incorrect statement as to a material fact which he or she knew or should have known to be incorrect; or

(2) Failed to provide information which he or she knew or should have known to be material; or

(3) Accepted a payment which he or she knew or should have known to be incorrect. (This provision applies only to the overpaid individual.)

(b) Whether or not OWCP determines that an individual was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the individual's capacity to realize that he or she is being overpaid.

§ 10.434 If OWCP finds that the recipient of an overpayment was not at fault, what criteria are used to decide whether to waive recovery of it?

If OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless:

(a) Adjustment or recovery of the overpayment would defeat the purpose of the FECA (see § 10.436), or

(b) Adjustment or recovery of the overpayment would be against equity and good conscience (see § 10.437).

§ 10.435 Is an individual responsible for an overpayment that resulted from an error made by OWCP or another Government agency?

(a) The fact that OWCP may have erred in making the overpayment, or that the overpayment may have resulted from an error by another Government agency, does not by itself relieve the individual who received the overpayment from liability for repayment if the individual also was at fault in accepting the overpayment.

(b) However, OWCP may find that the individual was not at fault if failure to report an event affecting compensation benefits, or acceptance of an incorrect payment, occurred because:

(1) The individual relied on misinformation given in writing by OWCP (or by another Government agency which he or she had reason to believe was connected with the administration of benefits) as to the interpretation of a pertinent provision of the FECA or its regulations; or

(2) OWCP erred in calculating cost-of-living increases, schedule award length and/or percentage of impairment, or loss of wage-earning capacity.

§ 10.436 Under what circumstances would recovery of an overpayment defeat the purpose of the FECA?

Recovery of an overpayment will defeat the purpose of the FECA if such recovery would cause hardship to a currently or formerly entitled beneficiary because:

(a) The beneficiary from whom OWCP seeks recovery needs substantially all of his or her current income (including compensation benefits) to meet current ordinary and necessary living expenses; and

(b) The beneficiary's assets do not exceed a specified amount as determined by OWCP from data furnished by the Bureau of Labor Statistics. A higher amount is specified for a beneficiary with one or more dependents.

§ 10.437 Under what circumstances would recovery of an overpayment be against equity and good conscience?

(a) Recovery of an overpayment is considered to be against equity and good conscience when any individual who received an overpayment would experience severe financial hardship in attempting to repay the debt.

(b) Recovery of an overpayment is also considered to be against equity and good conscience when any individual, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse. In making such a decision, OWCP does not consider the individual's current ability to repay the overpayment.

(1) To establish that a valuable right has been relinquished, it must be shown that the right was in fact valuable, that it cannot be regained, and that the action was based chiefly or solely in reliance on the payments or on the notice of payment. Donations to charitable causes or gratuitous transfers of funds to other individuals are not considered relinquishments of valuable rights.

(2) To establish that an individual's position has changed for the worse, it must be shown that the decision made would not otherwise have been made

but for the receipt of benefits, and that this decision resulted in a loss.

§ 10.438 Can OWCP require the individual who received the overpayment to submit additional financial information?

(a) The individual who received the overpayment is responsible for providing information about income, expenses and assets as specified by OWCP. This information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the FECA, or be against equity and good conscience. This information will also be used to determine the repayment schedule, if necessary.

(b) Failure to submit the requested information within 30 days of the request shall result in denial of waiver, and no further request for waiver shall be considered until the requested information is furnished.

§ 10.439 What is addressed at a pre-recoupment hearing?

At a pre-recoupment hearing, the OWCP representative will consider all issues in the claim on which a formal decision has been issued. Such a hearing will thus fulfill OWCP's obligation to provide pre-recoupment rights and a hearing under 5 U.S.C. 8124(b). Pre-recoupment hearings shall be conducted in exactly the same manner as provided in §10.615 through §10.622.

§ 10.440 How does OWCP communicate its final decision concerning recovery of an overpayment, and what appeal right accompanies it?

(a) OWCP will send a copy of the final decision to the individual from whom recovery is sought; his or her representative, if any; and the employing agency.

(b) The only review of a final decision concerning an overpayment is to the Employees' Compensation Appeals Board. The provisions of 5 U.S.C. 8124(b) (concerning hearings) and 5 U.S.C. 8128(a) (concerning reconsiderations) do not apply to such a decision.

§ 10.441 How are overpayments collected?

(a) When an overpayment has been made to an individual who is entitled to further payments, the individual shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. If no refund is made, OWCP shall decrease later payments of compensation, taking into account the probable extent of future payments, the rate of compensation, the financial circumstances of the individual, and any other relevant factors, so as to minimize any hardship. Should the individual die before collection has been completed, collection shall be made by decreasing later payments, if any, payable under the FECA with respect to the individual's death.

(b) When an overpayment has been made to an individual who is not entitled to further payments, the individual shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966 (as amended) and may be reported to the Internal Revenue Service as income. If the individual fails to make such refund, OWCP may recover the same through any available means, including offset of salary, annuity benefits, or other Federal payments, including tax refunds as authorized by the Tax Refund Offset Program, or referral of the debt to a collection agency or to the Department of Justice.

Subpart F—Continuing Benefits

RULES AND EVIDENCE

§ 10.500 What are the basic rules governing continuing receipt of compensation benefits and return to work?

(a) Benefits are available only while the effects of a work-related condition continue. Compensation for wage loss due to disability is available only for any periods during which an employee's work-related medical condition prevents him or her from earning the wages earned before the work-related injury. Payment of medical benefits is available for all treatment necessary due to a work-related medical condition.

(b) Each disabled employee is obligated to perform such work as he or

she can, and OWCP's goal is to return each disabled employee to suitable work as soon as he or she is medically able. In determining what constitutes ''suitable work'' for a particular disabled employee, OWCP considers the employee's current physical limitations, whether the work is available within the employee's demonstrated commuting area, the employee's qualifications to perform such work, and other relevant factors. (See §10.508 with respect to the payment of relocation expenses.)

§10.501 What medical evidence is necessary to support continuing receipt of compensation benefits?

(a) The employee is responsible for providing sufficient medical evidence to justify payment of any compensation sought.

(1) To support payment of continuing compensation, narrative medical evidence must be submitted whenever OWCP requests it but ordinarily not less than once a year. It must contain a physician's rationalized opinion as to whether the specific period of alleged disability is causally related to the employee's accepted injury or illness.

(2) The physician's opinion must be based on the facts of the case and the complete medical background of the employee, must be one of reasonable medical certainty and must include objective findings in support of its conclusions. Subjective complaints of pain are not sufficient, in and of themselves, to support payment of continuing compensation. Likewise, medical limitations based solely on the fear of a possible future injury are also not sufficient to support payment of continuing compensation. See §10.330 for a fuller discussion of medical evidence.

(b) OWCP may require any kind of non-invasive testing to determine the employee's functional capacity. Failure to undergo such testing will result in a suspension of benefits. In addition, OWCP may direct the employee to undergo a second opinion or referee examination in any case it deems appropriate (see §§10.320 and 10.321).

§10.502 How does OWCP evaluate evidence in support of continuing receipt of compensation benefits?

In considering the medical and factual evidence, OWCP will weigh the probative value of the attending physician's report, any second opinion physician's report, any other medical reports, or any other evidence in the file. If OWCP determines that the medical evidence supporting one conclusion is more consistent, logical, and well-reasoned than evidence supporting a contrary conclusion, OWCP will use the conclusion that is supported by the weight of the medical evidence as the basis for awarding or denying further benefits. If medical reports that are equally well-reasoned support inconsistent determinations of an issue under consideration, OWCP will direct the employee to undergo a referee examination to resolve the issue. The results of the referee examination will be given special weight in determining the issue.

§10.503 Under what circumstances may OWCP reduce or terminate compensation benefits?

Once OWCP has advised the employee that it has accepted a claim and has either approved continuation of pay or paid medical benefits or compensation, benefits will not be terminated or reduced unless the weight of the evidence establishes that:

(a) The disability for which compensation was paid has ceased;

(b) The disabling condition is no longer causally related to the employment;

(c) The employee is only partially disabled;

(d) The employee has returned to work;

(e) The beneficiary was convicted of fraud in connection with a claim under the FECA, or the beneficiary was incarcerated based on any felony conviction; or

(f) OWCP's initial decision was in error.

RETURN TO WORK—EMPLOYER'S RESPONSIBILITIES

§ 10.505 What actions must the employer take?

Upon authorizing medical care, the employer should advise the employee in writing as soon as possible of his or her obligation to return to work under § 10.210 and as defined in this subpart. The term ''return to work'' as used in this subpart is not limited to returning to work at the employee's normal worksite or usual position, but may include returning to work at other locations and in other positions. In general, the employer should make all reasonable efforts to place the employee in his or her former or an equivalent position, in accordance with 5 U.S.C. 8151(b)(2), if the employee has fully recovered after one year. The Office of Personnel Management (not OWCP) administers this provision.

(a) Where the employer has specific alternative positions available for partially disabled employees, the employer should advise the employee in writing of the specific duties and physical requirements of those positions.

(b) Where the employer has no specific alternative positions available for an employee who can perform restricted or limited duties, the employer should advise the employee of any accommodations the agency can make to accommodate the employee's limitations due to the injury.

§ 10.506 May the employer monitor the employee's medical care?

The employer may monitor the employee's medical progress and duty status by obtaining periodic medical reports. Form CA–17 is usually adequate for this purpose. To aid in returning an injured employee to suitable employment, the employer may also contact the employee's physician in writing concerning the work limitations imposed by the effects of the injury and possible job assignments. (However, the employer shall not contact the physician by telephone or through personal visit.) When such contact is made, the employer shall send a copy of any such correspondence to OWCP and the employee, as well as a copy of the physician's response when received. The employer may also contact the employee at reasonable intervals to request periodic medical reports addressing his or her ability to return to work.

§ 10.507 How should the employer make an offer of suitable work?

Where the attending physician or OWCP notifies the employer in writing that the employee is partially disabled (that is, the employee can perform some work but not return to the position held at date of injury), the employer should act as follows:

(a) If the employee can perform in a specific alternative position available in the agency, and the employer has advised the employee in writing of the specific duties and physical requirements, the employer shall notify the employee in writing immediately of the date of availability.

(b) If the employee can perform restricted or limited duties, the employer should determine whether such duties are available or whether an existing job can be modified. If so, the employer shall advise the employee in writing of the duties, their physical requirements and availability.

(c) The employer must make any job offer in writing. However, the employer may make a job offer verbally as long as it provides the job offer to the employee in writing within two business days of the verbal job offer.

(d) The offer must include a description of the duties of the position, the physical requirements of those duties, and the date by which the employee is either to return to work or notify the employer of his or her decision to accept or refuse the job offer. The employer must send a complete copy of any job offer to OWCP when it is sent to the employee.

§ 10.508 May relocation expenses be paid for an employee who would need to move to accept an offer of reemployment?

If possible, the employer should offer suitable reemployment in the location where the employee currently resides. If this is not practical, the employer may offer suitable reemployment at the employee's former duty station or other location. Where the distance between the location of the offered job

and the location where the employee currently resides is at least 50 miles, OWCP may pay such relocation expenses as are considered reasonable and necessary if the employee has been terminated from the agency's employment rolls and would incur relocation expenses by accepting the offered reemployment. OWCP may also pay such relocation expenses when the new employer is other than a Federal employer. OWCP will notify the employee that relocation expenses are payable if it makes a finding that the job is suitable. To determine whether a relocation expense is reasonable and necessary, OWCP shall use as a guide the Federal travel regulations for permanent changes of duty station.

§ 10.509 If an employee's light-duty job is eliminated due to downsizing, what is the effect on compensation?

(a) In general, an employee will not be considered to have experienced a compensable recurrence of disability as defined in § 10.5(x) merely because his or her employer has eliminated the employee's light-duty position in a reduction-in-force or some other form of downsizing. When this occurs, OWCP will determine the employee's wage-earning capacity based on his or her actual earnings in such light-duty position if this determination is appropriate on the basis that such earnings fairly and reasonably represent the employee's wage-earning capacity and such a determination has not already been made.

(b) For the purposes of this section only, a *light-duty position* means a classified position to which the injured employee has been formally reassigned that conforms to the established physical limitations of the injured employee and for which the employer has already prepared a written position description such that the position constitutes ''regular'' Federal employment. In the absence of a ''light-duty position'' as described in this paragraph, OWCP will assume that the employee was instead engaged in noncompetitive employment which does not represent the employee's wage-earning capacity, i.e., work of the type provided to injured employees who cannot otherwise be employed by the Federal Government or in any well-known branch of the general labor market.

Return to Work—Employee's Responsibilities

§ 10.515 What actions must the employee take with respect to returning to work?

(a) If an employee can resume regular Federal employment, he or she must do so. No further compensation for wage loss is payable once the employee has recovered from the work-related injury to the extent that he or she can perform the duties of the position held at the time of injury, or earn equivalent wages.

(b) If an employee cannot return to the job held at the time of injury due to partial disability from the effects of the work-related injury, but has recovered enough to perform some type of work, he or she must seek work. In the alternative, the employee must accept suitable work offered to him or her. (See § 10.500 for a definition of ''suitable work''.) This work may be with the original employer or through job placement efforts made by or on behalf of OWCP.

(c) If the employer has advised an employee in writing that specific alternative positions exist within the agency, the employee shall provide the description and physical requirements of such alternate positions to the attending physician and ask whether and when he or she will be able to perform such duties.

(d) If the employer has advised an employee that it is willing to accommodate his or her work limitations, the employee shall so advise the attending physician and ask him or her to specify the limitations imposed by the injury. The employee is responsible for advising the employer immediately of these limitations.

(e) From time to time, OWCP may require the employee to report his or her efforts to obtain suitable employment, whether with the Federal Government, State and local Governments, or in the private sector.

§ 10.516 How will an employee know if OWCP considers a job to be suitable?

OWCP shall advise the employee that it has found the offered work to be suitable and afford the employee 30 days to accept the job or present any reasons to counter OWCP's finding of suitability. If the employee presents such reasons, and OWCP determines that the reasons are unacceptable, it will notify the employee of that determination and that he or she has 15 days in which to accept the offered work without penalty. At that point in time, OWCP's notification need not state the reasons for finding that the employee's reasons are not acceptable.

§ 10.517 What are the penalties for refusing to accept a suitable job offer?

(a) 5 U.S.C. 8106(c) provides that a partially disabled employee who refuses to seek suitable work, or refuses to or neglects to work after suitable work is offered to or arranged for him or her, is not entitled to compensation. An employee who refuses or neglects to work after suitable work has been offered or secured for him or her has the burden to show that this refusal or failure to work was reasonable or justified.

(b) After providing the two notices described in §10.516, OWCP will terminate the employee's entitlement to further compensation under 5 U.S.C. 8105, 8106, and 8107, as provided by 5 U.S.C. 8106(c)(2). However, the employee remains entitled to medical benefits as provided by 5 U.S.C. 8103.

§ 10.518 Does OWCP provide services to help employees return to work?

(a) OWCP may, in its discretion, provide vocational rehabilitation services as authorized by 5 U.S.C. 8104. These services include assistance from registered nurses working under the direction of OWCP. Among other things, these nurses visit the worksite, ensure that the duties of the position do not exceed the medical limitations as represented by the weight of medical evidence established by OWCP, and address any problems the employee may have in adjusting to the work setting. The nurses do not evaluate medical evidence; OWCP claims staff perform this function.

(b) Vocational rehabilitation services may also include vocational evaluation, testing, training, and placement services with either the original employer or a new employer, when the injured employee cannot return to the job held at the time of injury. These services also include functional capacity evaluations, which help to tailor individual rehabilitation programs to employees' physical reconditioning and behavioral modification needs, and help employees to meet the demands of current or potential jobs.

§ 10.519 What action will OWCP take if an employee refuses to undergo vocational rehabilitation?

Under 5 U.S.C. 8104(a), OWCP may direct a permanently disabled employee to undergo vocational rehabilitation. To ensure that vocational rehabilitation services are available to all who might be entitled to benefit from them, an injured employee who has a loss of wage-earning capacity shall be presumed to be ''permanently disabled,'' for purposes of this section only, unless and until the employee proves that the disability is not permanent. If an employee without good cause fails or refuses to apply for, undergo, participate in, or continue to participate in a vocational rehabilitation effort when so directed, OWCP will act as follows:

(a) Where a suitable job has been identified, OWCP will reduce the employee's future monetary compensation based on the amount which would likely have been his or her wage-earning capacity had he or she undergone vocational rehabilitation. OWCP will determine this amount in accordance with the job identified through the vocational rehabilitation planning process, which includes meetings with the OWCP nurse and the employer. The reduction will remain in effect until such time as the employee acts in good faith to comply with the direction of OWCP.

(b) Where a suitable job has not been identified, because the failure or refusal occurred in the early but necessary stages of a vocational rehabilitation effort (that is, meetings with the OWCP nurse, interviews, testing,

counseling, functional capacity evaluations, and work evaluations), OWCP cannot determine what would have been the employee's wage-earning capacity.

(c) Under the circumstances identified in paragraph (b) of this section, in the absence of evidence to the contrary, OWCP will assume that the vocational rehabilitation effort would have resulted in a return to work with no loss of wage-earning capacity, and OWCP will reduce the employee's monetary compensation accordingly (that is, to zero). This reduction will remain in effect until such time as the employee acts in good faith to comply with the direction of OWCP.

§ 10.520 How does OWCP determine compensation after an employee completes a vocational rehabilitation program?

After completion of a vocational rehabilitation program, OWCP may adjust compensation to reflect the injured worker's wage-earning capacity. Actual earnings will be used if they fairly and reasonably reflect the earning capacity. The position determined to be the goal of a training plan is assumed to represent the employee's earning capacity if it is suitable and performed in sufficient numbers so as to be reasonably available, whether or not the employee is placed in such a position.

Reports of Earnings From Employment and Self-Employment

§ 10.525 What information must the employee report?

(a) An employee who is receiving compensation for partial or total disability must advise OWCP immediately of any return to work, either part-time or full-time. In addition, an employee who is receiving compensation for partial or total disability will periodically be required to submit a report of earnings from employment or self-employment, either part-time or full-time. (See § 10.5(g) for a definition of ''earnings''.)

(b) The employee must report even those earnings which do not seem likely to affect his or her level of benefits. Many kinds of income, though not all, will result in reduction of compensation benefits. While earning income will not necessarily result in a reduction of compensation, failure to report income may result in forfeiture of all benefits paid during the reporting period.

§ 10.526 Must the employee report volunteer activities?

An employee who is receiving compensation for partial or total disability is periodically required to report volunteer activity or any other kind of activity which shows that the employee is no longer totally disabled for work.

§ 10.527 Does OWCP verify reports of earnings?

To make proper determinations of an employee's entitlement to benefits, OWCP may verify the earnings reported by the employee through a variety of means, including but not limited to computer matches with the Office of Personnel Management and inquiries to the Social Security Administration. Also, OWCP may perform computer matches with records of State agencies, including but not limited to workers' compensation administrations, to determine whether private employers are paying workers' compensation insurance premiums for recipients of benefits under the FECA.

§ 10.528 What action will OWCP take if the employee fails to file a report of activity indicating an ability to work?

OWCP periodically requires each employee who is receiving compensation benefits to complete an affidavit as to any work, or activity indicating an ability to work, which the employee has performed for the prior 15 months. If an employee who is required to file such a report fails to do so within 30 days of the date of the request, his or her right to compensation for wage loss under 5 U.S.C. 8105 or 8106 is suspended until OWCP receives the requested report. At that time, OWCP will reinstate compensation retroactive to the date of suspension if the employee remains entitled to compensation.

§ 10.529 What action will OWCP take if the employee files an incomplete report?

(a) If an employee knowingly omits or understates any earnings or work activity in making a report, he or she shall forfeit the right to compensation with respect to any period for which the report was required. A false or evasive statement, omission, concealment, or misrepresentation with respect to employment activity or earnings in a report may also subject an employee to criminal prosecution.

(b) Where the right to compensation is forfeited, OWCP shall recover any compensation already paid for the period of forfeiture pursuant to 5 U.S.C. 8129 and other relevant statutes.

REPORTS OF DEPENDENTS

§ 10.535 How are dependents defined, and what information must the employee report?

(a) Dependents in disability cases are defined in § 10.405. While the employee has one or more dependents, the employee's basic compensation for wage loss or for permanent impairment shall be augmented as provided in 5 U.S.C. 8110. (The rules for death claims are found in § 10.414.)

(b) An employee who is receiving augmented compensation on account of dependents must advise OWCP immediately of any change in the number or status of dependents. The employee should also promptly refund to OWCP any amounts received on account of augmented compensation after the right to receive augmented compensation has ceased. Any difference between actual entitlement and the amount already paid beyond the date entitlement ended is an overpayment of compensation and may be recovered pursuant to 5 U.S.C. 8129 and other relevant statutes.

(c) An employee who is receiving augmented compensation shall be periodically required to submit a statement as to any dependents, or to submit supporting documents such as birth or marriage certificates or court orders, to determine if he or she is still entitled to augmented compensation.

§ 10.536 What is the penalty for failing to submit a report of dependents?

If an employee fails to submit a requested statement or supporting document within 30 days of the date of the request, OWCP will suspend his or her right to augmented compensation until OWCP receives the requested statement or supporting document. At that time, OWCP will reinstate augmented compensation retroactive to the date of suspension, provided that the employee is entitled to receive augmented compensation.

§ 10.537 What reports are needed when compensation payments continue for children over age 18?

(a) Compensation payable on behalf of a child that would otherwise end when the child reaches 18 years of age will continue if and for so long as he or she is not married and is either a student as defined in 5 U.S.C. 8101(17), or physically or mentally incapable of self-support.

(b) At least twice each year, OWCP will ask an employee who receives compensation based on the student status of a child to provide proof of continuing entitlement to such compensation, including certification of school enrollment.

(c) Likewise, at least twice each year, OWCP will ask an employee who receives compensation based on a child's physical or mental inability to support himself or herself to submit a medical report verifying that the child's medical condition persists and that it continues to preclude self-support.

(d) If an employee fails to submit proof within 30 days of the date of the request, OWCP will suspend the employee's right to compensation until the requested information is received. At that time OWCP will reinstate compensation retroactive to the date of suspension, provided the employee is entitled to such compensation.

REDUCTION AND TERMINATION OF COMPENSATION

§ 10.540 When and how is compensation reduced or terminated?

(a) Except as provided in paragraphs (b) and (c) of this section, where the

evidence establishes that compensation should be either reduced or terminated, OWCP will provide the beneficiary with written notice of the proposed action and give him or her 30 days to submit relevant evidence or argument to support entitlement to continued payment of compensation. This notice will include a description of the reasons for the proposed action and a copy of the specific evidence upon which OWCP is basing its determination. Payment of compensation will continue until any evidence or argument submitted has been reviewed and an appropriate decision has been issued, or until 30 days have elapsed if no additional evidence or argument is submitted.

(b) OWCP will not provide such written notice when the beneficiary has no reasonable basis to expect that payment of compensation will continue. For example, when a claim has been made for a specific period of time and that specific period expires, no written notice will be given. Written notice will also not be given when a beneficiary dies, when OWCP either reduces or terminates compensation upon an employee's return to work, when OWCP terminates only medical benefits after a physician indicates that further medical treatment is not necessary or has ended, or when OWCP denies payment for a particular medical expense.

(c) OWCP will also not provide such written notice when compensation is terminated, suspended or forfeited due to one of the following: A beneficiary's conviction for fraud in connection with a claim under the FECA; a beneficiary's incarceration based on any felony conviction; an employee's failure to report earnings from employment or self-employment; an employee's failure or refusal to either continue performing suitable work or to accept an offer of suitable work; or an employee's refusal to undergo or obstruction of a directed medical examination or treatment for substance abuse.

§ 10.541 What action will OWCP take after issuing written notice of its intention to reduce or terminate compensation?

(a) If the beneficiary submits evidence or argument prior to the issuance of the decision, OWCP will evaluate it in light of the proposed action and undertake such further development as it may deem appropriate, if any. Evidence or argument which is repetitious, cumulative, or irrelevant will not require any further development. If the beneficiary does not respond within 30 days of the written notice, OWCP will issue a decision consistent with its prior notice. OWCP will not grant any request for an extension of this 30-day period.

(b) Evidence or argument which refutes the evidence upon which the proposed action was based will result in the continued payment of compensation. If the beneficiary submits evidence or argument which fails to refute the evidence upon which the proposed action was based but which requires further development, OWCP will not provide the beneficiary with another notice of its proposed action upon completion of such development. Once any further development of the evidence is completed, OWCP will either continue payment or issue a decision consistent with its prior notice.

Subpart G—Appeals Process

§ 10.600 How can final decisions of OWCP be reviewed?

There are three methods for reviewing a formal decision of the OWCP (§§ 10.125–10.127 discuss how decisions are made). These methods are: reconsideration by the district office; a hearing before an OWCP hearing representative; and appeal to the Employees' Compensation Appeals Board (ECAB). For each method there are time limitations and other restrictions which may apply, and not all options are available for all decisions, so the employee should consult the requirements set forth below. Further rules governing appeals to the ECAB are found at part 501 of this title.

RECONSIDERATIONS AND REVIEWS BY THE DIRECTOR

§ 10.605 What is reconsideration?

The FECA provides that the Director may review an award for or against compensation upon application by an employee (or his or her representative) who receives an adverse decision. The employee shall exercise this right through a request to the district office. The request, along with the supporting statements and evidence, is called the ''application for reconsideration.''

§ 10.606 How does a claimant request reconsideration?

(a) An employee (or representative) seeking reconsideration should send the application for reconsideration to the address as instructed by OWCP in the final decision.

(b) The application for reconsideration, including all supporting documents, must:

(1) Be submitted in writing;

(2) Set forth arguments and contain evidence that either:

(i) Shows that OWCP erroneously applied or interpreted a specific point of law;

(ii) Advances a relevant legal argument not previously considered by OWCP; or

(iii) Constitutes relevant and pertinent new evidence not previously considered by OWCP.

§ 10.607 What is the time limit for requesting reconsideration?

(a) An application for reconsideration must be sent within one year of the date of the OWCP decision for which review is sought. If submitted by mail, the application will be deemed timely if postmarked by the U.S. Postal Service within the time period allowed. If there is no such postmark, or it is not legible, other evidence such as (but not limited to) certified mail receipts, certificate of service, and affidavits, may be used to establish the mailing date.

(b) OWCP will consider an untimely application for reconsideration only if the application demonstrates clear evidence of error on the part of OWCP in its most recent merit decision. The application must establish, on its face, that such decision was erroneous.

(c) The year in which a claimant has to timely request reconsideration shall not include any period subsequent to an OWCP decision for which the claimant can establish through probative medical evidence that he or she is unable to communicate in any way and that his or her testimony is necessary in order to obtain modification of the decision.

§ 10.608 How does OWCP decide whether to grant or deny the request for reconsideration?

(a) A timely request for reconsideration may be granted if OWCP determines that the employee has presented evidence and/or argument that meets at least one of the standards described in §10.606(b)(2). If reconsideration is granted, the case is reopened and the case is reviewed on its merits (see §10.609).

(b) Where the request is timely but fails to meet at least one of the standards described in §10.606(b)(2), or where the request is untimely and fails to present any clear evidence of error, OWCP will deny the application for reconsideration without reopening the case for a review on the merits. A decision denying an application for reconsideration cannot be the subject of another application for reconsideration. The only review for this type of nonmerit decision is an appeal to the ECAB (see §10.625), and OWCP will not entertain a request for reconsideration or a hearing on this decision denying reconsideration.

§ 10.609 How does OWCP decide whether new evidence requires modification of the prior decision?

When application for reconsideration is granted, OWCP will review the decision for which reconsideration is sought on the merits and determine whether the new evidence or argument requires modification of the prior decision.

(a) After OWCP decides to grant reconsideration, but before undertaking the review, OWCP will send a copy of the reconsideration application to the employer, which will have 20 days from the date sent to comment or submit

relevant documents. OWCP will provide any such comments to the employee, who will have 20 days from the date the comments are sent to him or her within which to comment. If no comments are received from the employer, OWCP will proceed with the merit review of the case.

(b) A claims examiner who did not participate in making the contested decision will conduct the merit review of the claim. When all evidence has been reviewed, OWCP will issue a new merit decision, based on all the evidence in the record. A copy of the decision will be provided to the agency.

(c) An employee dissatisfied with this new merit decision may again request reconsideration under this subpart or appeal to the ECAB. An employee may not request a hearing on this decision.

§ 10.610 What is a review by the Director?

The FECA specifies that an award for or against payment of compensation may be reviewed at any time on the Director's own motion. Such review may be made without regard to whether there is new evidence or information. If the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded, or award compensation previously denied. A review on the Director's own motion is not subject to a request or petition and none shall be entertained.

(a) The decision whether or not to review an award under this section is solely within the discretion of the Director. The Director's exercise of this discretion is not subject to review by the ECAB, nor can it be the subject of a reconsideration or hearing request.

(b) Where the Director reviews an award on his or her own motion, any resulting decision is subject as appropriate to reconsideration, a hearing and/or appeal to the ECAB. Jurisdiction on review or on appeal to ECAB is limited to a review of the merits of the resulting decision. The Director's determination to review the award is not reviewable.

HEARINGS

§ 10.615 What is a hearing?

A hearing is a review of an adverse decision by a hearing representative. Initially, the claimant can choose between two formats: An oral hearing or a review of the written record. At the discretion of the hearing representative, an oral hearing may be conducted by telephone or teleconference. In addition to the evidence of record, the employee may submit new evidence to the hearing representative.

§ 10.616 How does a claimant obtain a hearing?

(a) A claimant, injured on or after July 4, 1966, who has received a final adverse decision by the district office may obtain a hearing by writing to the address specified in the decision. The hearing request must be sent within 30 days (as determined by postmark or other carrier's date marking) of the date of the decision for which a hearing is sought. The claimant must not have previously submitted a reconsideration request (whether or not it was granted) on the same decision.

(b) The claimant may specify the type of hearing desired when making the original hearing request. If the request does not specify a format, OWCP will schedule an oral hearing. The claimant can request a change in the format of the hearing by making a written request to the Branch of Hearings and Review. OWCP will grant a request received by the Branch of Hearings and Review within 30 days of: The date OWCP acknowledges the initial hearing request, or the date OWCP issues a notice setting a date for an oral hearing, in cases where the initial request was for, or was treated as a request for, an oral hearing. A request received after those dates will be subject to OWCP's discretion. The decision to grant or deny a change of format is not reviewable.

§ 10.617 How is an oral hearing conducted?

(a) The hearing representative retains complete discretion to set the

time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved.

(b) Unless otherwise directed in writing by the claimant, the hearing representative will mail a notice of the time and place of the oral hearing to the claimant and any representative at least 30 days before the scheduled date. The employer will also be mailed a notice at least 30 days before the scheduled date.

(c) The hearing is an informal process, and the hearing representative is not bound by common law or statutory rules of evidence, by technical or formal rules of procedure or by section 5 of the Administrative Procedure Act, but the hearing representative may conduct the hearing in such manner as to best ascertain the rights of the claimant. During the hearing process, the claimant may state his or her arguments and present new written evidence in support of the claim.

(d) Testimony at oral hearings is recorded, then transcribed and placed in the record. Oral testimony shall be made under oath.

(e) OWCP will furnish a transcript of the oral hearing to the claimant and the employer, who have 20 days from the date it is sent to comment. Any comments received from the employer shall be sent to the claimant, who will be given an additional 20 days to comment from the date OWCP sends any agency comments.

(f) The hearing remains open for the submittal of additional evidence until 30 days after the hearing is held, unless the hearing representative, in his or her sole discretion, grants an extension. Only one such extension may be granted. A copy of the decision will be mailed to the claimant's last known address, to any representative, and to the employer.

(g) The hearing representative determines the conduct of the oral hearing and may terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative at or near the place of the oral presentation.

§ 10.618 How is a review of the written record conducted?

(a) The hearing representative will review the official record and any additional evidence submitted by the claimant and by the agency. The hearing representative may also conduct whatever investigation is deemed necessary. New evidence and arguments are to be submitted at any time up to the time specified by OWCP, but they should be submitted as soon as possible to avoid delaying the hearing process.

(b) The claimant should submit, with his or her application for review, all evidence or argument that he or she wants to present to the hearing representative. A copy of all pertinent material will be sent to the employer, which will have 20 days from the date it is sent to comment. (Medical evidence is not considered ''pertinent'' for review and comment by the agency, and it will therefore not be furnished to the agency. OWCP has sole responsibility for evaluating medical evidence.) The employer shall send any comments to the claimant, who will have 20 more days from the date of the agency's certificate of service to comment.

§ 10.619 May subpoenas be issued for witnesses and documents?

A claimant may request a subpoena, but the decision to grant or deny such a request is within the discretion of the hearing representative. The hearing representative may issue subpoenas for the attendance and testimony of witnesses, and for the production of books, records, correspondence, papers or other relevant documents. Subpoenas are issued for documents only if they are relevant and cannot be obtained by other means, and for witnesses only where oral testimony is the best way to ascertain the facts.

(a) A claimant may request a subpoena only as part of the hearings process, and no subpoena will be issued under any other part of the claims process. To request a subpoena, the requestor must:

(1) Submit the request in writing and send it to the hearing representative as early as possible but no later than 60 days (as evidenced by postmark, electronic marker or other objective date

mark) after the date of the original hearing request.

(2) Explain why the testimony or evidence is directly relevant to the issues at hand, and a subpoena is the best method or opportunity to obtain such evidence because there are no other means by which the documents or testimony could have been obtained.

(b) No subpoena will be issued for attendance of employees of OWCP acting in their official capacities as decision-makers or policy administrators. For hearings taking the form of a review of the written record, no subpoena for the appearance of witnesses will be considered.

(c) The hearing representative issues the subpoena under his or her own name. It may be served in person or by certified mail, return receipt requested, addressed to the person to be served at his or her last known principal place of business or residence. A decision to deny a subpoena can only be appealed as part of an appeal of any adverse decision which results from the hearing.

§ 10.620 Who pays the costs associated with subpoenas?

(a) Witnesses who are not employees or former employees of the Federal Government shall be paid the same fees and mileage as paid for like services in the District Court of the United States where the subpoena is returnable, except that expert witnesses shall be paid a fee not to exceed the local customary fee for such services.

(b) Where OWCP asked that the witness submit evidence into the case record or asked that the witness attend, OWCP shall pay the fees and mileage. Where the claimant requested the subpoena, and where the witness submitted evidence into the record at the request of the claimant, the claimant shall pay the fees and mileage.

§ 10.621 What is the employer's role when an oral hearing has been requested?

(a) The employer may send one (or more, where appropriate) representative(s) to observe the proceeding, but the agency representative cannot give testimony or argument or otherwise participate in the hearing, except where the claimant or the hearing representative specifically asks the agency representative to testify.

(b) The hearing representative may deny a request by the claimant that the agency representative testify where the claimant cannot show that the testimony would be relevant or where the agency representative does not have the appropriate level of knowledge to provide such evidence at the hearing. The employer may also comment on the hearing transcript, as described in § 10.617(e).

§ 10.622 May a claimant withdraw a request for or postpone a hearing?

(a) The claimant and/or representative may withdraw the hearing request at any time up to and including the day the hearing is held, or the decision issued. Withdrawing the hearing request means the record is returned to the jurisdiction of the district office and no further requests for a hearing on the underlying decision will be considered.

(b) OWCP will entertain any reasonable request for scheduling the oral hearing, but such requests should be made at the time of the original application for hearing. Scheduling is at the sole discretion of the hearing representative, and is not reviewable. Once the oral hearing is scheduled and OWCP has mailed appropriate written notice to the claimant, the oral hearing cannot be postponed at the claimant's request for any reason except those stated in paragraph (c) of this section, unless the hearing representative can reschedule the hearing on the same docket (that is, during the same hearing trip). When the request to postpone a scheduled hearing does not meet the test of paragraph (c) of this section and cannot be accommodated on the docket, no further opportunity for an oral hearing will be provided. Instead, the hearing will take the form of a review of the written record and a decision issued accordingly. In the alternative, a teleconference may be substituted for the oral hearing at the discretion of the hearing representative.

(c) Where the claimant is hospitalized for a reason which is not elective, or where the death of the claimant's

parent, spouse, or child prevents attendance at the hearing, a postponement may be granted upon proper documentation.

REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB)

§ 10.625 What kinds of decisions may be appealed?

Only final decisions of OWCP may be appealed to the ECAB. However, certain types of final decisions, described in this part as not subject to further review, cannot be appealed to the ECAB. Decisions that are not appealable to the ECAB include: Decisions concerning the amounts payable for medical services, decisions concerning exclusion and reinstatement of medical providers, decisions by the Director to review an award on his or her own motion, and denials of subpoenas independent of the appeal of the underlying decision. In appeals before the ECAB, attorneys from the Office of the Solicitor of Labor shall represent OWCP.

§ 10.626 Who has jurisdiction of cases on appeal to the ECAB?

While a case is on appeal to the ECAB, OWCP has no jurisdiction over the claim with respect to issues which directly relate to the issue or issues on appeal. The OWCP continues to administer the claim and retains jurisdiction over issues unrelated to the issue or issues on appeal and issues which arise after the appeal as a result of ongoing administration of the case. Such issues would include, for example, the ability to terminate benefits where an individual returns to work while an appeal is pending at the ECAB.

Subpart H—Special Provisions

REPRESENTATION

§ 10.700 May a claimant designate a representative?

(a) The claims process under the FECA is informal. Unlike many workers' compensation laws, the employer is not a party to the claim, and OWCP acts as an impartial evaluator of the evidence. Nevertheless, a claimant may appoint one individual to represent his or her interests, but the appointment must be in writing.

(b) There can be only one representative at any one time, so after one representative has been properly appointed, OWCP will not recognize another individual as representative until the claimant withdraws the authorization of the first individual. In addition, OWCP will recognize only certain types of individuals (see §10.701).

(c) A properly appointed representative who is recognized by OWCP may make a request or give direction to OWCP regarding the claims process, including a hearing. This authority includes presenting or eliciting evidence, making arguments on facts or the law, and obtaining information from the case file, to the same extent as the claimant. Any notice requirement contained in this part or the FECA is fully satisfied if served on the representative, and has the same force and effect as if sent to the claimant.

§ 10.701 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under the FECA, unless that individual's service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and 208). A Federal employee may act as a representative only:

(a) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(b) While acting as a union representative, defined as any officially sanctioned union official, and no fee or gratuity is charged.

§ 10.702 How are fees for services paid?

A representative may charge the claimant a fee and other costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other charges. The claimant will not be reimbursed by OWCP, nor is OWCP in any way liable for the amount of the fee.

Administrative costs (mailing, copying, messenger services, travel and the

like, but not including secretarial services, paralegal and other activities) need not be approved before the representative collects them. Before any fee for services can be collected, however, the fee must be approved by the Secretary. (Collecting a fee without this approval may constitute a misdemeanor under 18 U.S.C. 292.)

§ 10.703 How are fee applications approved?

(a) *Fee Application.* (1) The representative must submit the fee application to the district office and/or the Branch of Hearings and Review, according to where the work for which the fee is charged was performed. The application shall contain the following:

(i) An itemized statement showing the representative's hourly rate, the number of hours worked and specifically identifying the work performed and a total amount charged for the representation (excluding administrative costs).

(ii) A statement of agreement or disagreement with the amount charged, signed by the claimant. The statement must also acknowledge that the claimant is aware that he or she must pay the fees and that OWCP is not responsible for paying the fee or other costs.

(2) An incomplete application will be returned with no further comment.

(b) *Approval where there is no dispute.* Where a fee application is accompanied by a signed statement indicating the claimant's agreement with the fee as described in paragraph (a)(1)(ii) of this section, the application is deemed approved.

(c) *Disputed requests.* (1) Where the claimant disagrees with the amount of the fee, as indicated in the statement accompanying the submittal, OWCP will evaluate the objection and decide whether or not to approve the request. OWCP will provide a copy of the request to the claimant and ask him or her to submit any further information in support of the objection within 15 days from the date the request is forwarded. After that period has passed, OWCP will evaluate the information received to determine whether the amount of the fee is substantially in excess of the value of services received by looking at the following factors:

(i) Usefulness of the representative's services;

(ii) The nature and complexity of the claim;

(iii) The actual time spent on development and presentation of the claim; and

(iv) Customary local charges for similar services.

(2) Where the claimant disputes the representative's request and files an objection with OWCP, an appealable decision will be issued.

THIRD PARTY LIABILITY

§ 10.705 When must an employee or other FECA beneficiary take action against a third party?

(a) If an injury or death for which benefits are payable under the FECA is caused, wholly or partially, by someone other than a Federal employee acting within the scope of his or her employment, the claimant can be required to take action against that third party.

(b) The Office of the Solicitor of Labor (SOL) is hereby delegated authority to administer the subrogation aspects of certain FECA claims for OWCP. Either OWCP or SOL can require a FECA beneficiary to assign his or her claim for damages to the United States or to prosecute the claim in his or her own name.

§ 10.706 How will a beneficiary know if OWCP or SOL has determined that action against a third party is required?

When OWCP determines that an employee or other FECA beneficiary must take action against a third party, it will notify the employee or beneficiary in writing. If the case is transferred to SOL, a second notification may be issued.

§ 10.707 What must a FECA beneficiary who is required to take action against a third party do to satisfy the requirement that the claim be "prosecuted"?

At a minimum, a FECA beneficiary must do the following:

(a) Seek damages for the injury or death from the third party, either through an attorney or on his or her own behalf;

(b) Either initiate a lawsuit within the appropriate statute of limitations period or obtain a written release of this obligation from OWCP or SOL unless recovery is possible through a negotiated settlement prior to filing suit;

(c) Refuse to settle or dismiss the case for any amount less than the amount necessary to repay OWCP's refundable disbursements, as defined in §10.714, without receiving permission from OWCP or SOL;

(d) Provide periodic status updates and other relevant information in response to requests from OWCP or SOL;

(e) Submit detailed information about the amount recovered and the costs of the suit on a ''Statement of Recovery'' form approved by OWCP; and

(f) Pay any required refund.

§10.708 Can a FECA beneficiary who refuses to comply with a request to assign a claim to the United States or to prosecute the claim in his or her own name be penalized?

When a FECA beneficiary refuses a request to either assign a claim or prosecute a claim in his or her own name, OWCP may determine that he or she has forfeited his or her right to all past or future compensation for the injury with respect to which the request is made. Alternatively, OWCP may also suspend the FECA beneficiary's compensation payments until he or she complies with the request.

§10.709 What happens if a beneficiary directed by OWCP or SOL to take action against a third party does not believe that a claim can be successfully prosecuted at a reasonable cost?

If a beneficiary consults an attorney and is informed that a suit for damages against a third party for the injury or death for which benefits are payable is unlikely to prevail or that the costs of such a suit are not justified by the potential recovery, he or she should request that OWCP or SOL release him or her from the obligation to proceed. This request should be in writing and provide evidence of the attorney's opinion. If OWCP or SOL agrees, the beneficiary will not be required to take further action against the third party.

§10.710 Under what circumstances must a recovery of money or other property in connection with an injury or death for which benefits are payable under the FECA be reported to OWCP or SOL?

Any person who has filed a FECA claim that has been accepted by OWCP (whether or not compensation has been paid), or who has received FECA benefits in connection with a claim filed by another, is required to notify OWCP or SOL of the receipt of money or other property as a result of a settlement or judgment in connection with the circumstances of that claim. This includes an injured employee, and in the case of a claim involving the death of an employee, a spouse, children or other dependents entitled to receive survivor's benefits. OWCP or SOL should be notified in writing within 30 days of the receipt of such money or other property or the acceptance of the FECA claim, whichever occurs later.

§10.711 How much of any settlement or judgment must be paid to the United States?

The statute permits a FECA beneficiary to retain, as a minimum, one-fifth of the net amount of money or property remaining after a reasonable attorney's fee and the costs of litigation have been deducted from the third-party recovery. The United States shares in the litigation expense by allowing the beneficiary to retain, at the time of distribution, an amount equivalent to a reasonable attorney's fee proportionate to the refund due the United States. After the refund owed to the United States is calculated, the FECA beneficiary retains any surplus remaining, and this amount is credited, dollar for dollar, against future compensation for the same injury, as defined in §10.719. OWCP will resume the payment of compensation only after the FECA beneficiary has been awarded compensation which exceeds the amount of the surplus.

(a) The refund to the United States is calculated as follows, using the Statement of Recovery form approved by OWCP:

(1) Determine the gross recovery as set forth in §10.712;

(2) Subtract the amount of attorney's fees actually paid, but not more than the maximum amount of attorney's fees considered by OWCP or SOL to be reasonable, from the gross recovery (Subtotal A);

(3) Subtract the costs of litigation, as allowed by OWCP or SOL (Subtotal B);

(4) Subtract one fifth of Subtotal B from Subtotal B (Subtotal C);

(5) Compare Subtotal C and the refundable disbursements as defined in §10.714. Subtotal D is the lower of the two amounts.

(6) Multiply Subtotal D by a percentage that is determined by dividing the gross recovery into the amount of attorney's fees actually paid, but not more than the maximum amount of attorney's fees considered by OWCP or SOL to be reasonable, to determine the Government's allowance for attorney's fees, and subtract this amount from Subtotal D.

(b) The credit against future benefits (also referred to as the surplus) is calculated as follows:

(1) If Subtotal C, as calculated according to paragraph (a)(4) of this section, is less than the refundable disbursements, as defined in §10.714, there is no credit to be applied against future benefits;

(2) If Subtotal C is greater than the refundable disbursements, the credit against future benefits (or surplus) amount is determined by subtracting the refundable disbursements from Subtotal C.

(c) An example of how these calculations are made follows. In this example, a Federal employee sues another party for causing injuries for which the employee has received $22,000 in benefits under the FECA, subject to refund. The suit is settled and the injured employee receives $100,000, all of which was for his injury. The injured worker paid attorney's fees of $25,000 and costs for the litigation of $3,000.

(1) Gross recovery	$100,000
Attorney's fees	−25,000
(2) Subtotal A	75,000
(3) Costs of suit	−3,000
Subtotal B	72,000
One-fifth of Subtotal B	−14,400
(4) Subtotal C	57,600
Refundable Disbursements	22,000
(5) Subtotal D (lower of Subtotal C or refundable disbursements)	22,000
(6) Government's allowance for attorney's fees [25,000 / 100,000) × 22,000] (attorney's fees divided by gross recovery then multiplied by Subtotal D)	−5,500
Refund to the United States	16,500
(7) Credit against future benefits [57,600 − 22,000] (Subtotal C minus refundable disbursements)	35,600

§10.712 What amounts are included in the gross recovery?

(a) When a settlement or judgment is paid to, or for, one individual, the entire amount, except for the portion representing damage to real or personal property, is reported as the gross recovery. If a settlement or judgment is paid to or for more than one individual or in more than one capacity, such as a joint payment to a husband and wife for personal injury and loss of consortium or a payment to a spouse representing both loss of consortium and wrongful death, the gross recovery to be reported is the amount allocated to the injured employee. If a judge or jury specifies the percentage of a contested verdict attributable to each of several plaintiffs, OWCP or SOL will accept that division.

(b) In any other case, where a judgment or settlement is paid to or on behalf of more than one individual, OWCP or SOL will determine the appropriate amount of the FECA beneficiary's gross recovery and advise the beneficiary of its determination. FECA beneficiaries may accept OWCP's or SOL's determination or demonstrate good cause for a different allocation. Whether to accept a specific allocation is at the discretion of SOL or OWCP.

§10.713 How is a structured settlement (that is, a settlement providing for receipt of funds over a specified period of time) treated for purposes of reporting the gross recovery?

In this situation, the gross recovery to be reported is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries.

§ 10.714 What amounts are included in the refundable disbursements?

The refundable disbursements of a specific claim consist of the total money paid by OWCP from the Employees' Compensation Fund with respect to that claim to or on behalf of a FECA beneficiary, less charges for any medical file review (i.e., the physician does not examine the employee) done at the request of OWCP. Charges for medical examinations also may be subtracted if the FECA beneficiary establishes that the examinations were required to be made available to the employee under a statute other than the FECA by the employing agency or at the employing agency's cost.

§ 10.715 Is a beneficiary required to pay interest on the amount of the refund due to the United States?

If the refund due to the United States is not submitted within 30 days of receiving a request for payment from SOL or OWCP, interest shall accrue on the refund due to the United States from the date of the request. The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury as published in the FEDERAL REGISTER (as of the date the request for payment is sent). Waiver of the collection of interest shall be in accordance with the provisions of the Department of Labor regulations on Federal Claims Collection governing waiver of interest, 29 CFR 20.61.

§ 10.716 If the required refund is not paid within 30 days of the request for repayment, can it be collected from payments due under the FECA?

If the required refund is not paid within 30 days of the request for payment, OWCP can, in its discretion, collect the refund by withholding all or part of any payments currently payable to the beneficiary under the FECA with respect to any injury. The waiver provisions of §§ 10.432 through 10.440 do not apply to such determinations.

§ 10.717 Is a settlement or judgment received as a result of allegations of medical malpractice in treating an injury covered by the FECA a gross recovery that must be reported to OWCP or SOL?

Since an injury caused by medical malpractice in treating an injury covered by the FECA is also an injury covered under the FECA, any recovery in a suit alleging such an injury is treated as a gross recovery that must be reported to OWCP or SOL.

§ 10.718 Are payments to a beneficiary as a result of an insurance policy which the beneficiary has purchased a gross recovery that must be reported to OWCP or SOL?

Since payments received by a FECA beneficiary pursuant to an insurance policy purchased by someone other than a liable third party are not payments in satisfaction of liability for causing an injury covered by the FECA, they are not considered a gross recovery covered by section 8132 that requires filing a Statement of Recovery and paying any required refund.

§ 10.719 If a settlement or judgment is received for more than one wound or medical condition, can the refundable disbursements paid on a single FECA claim be attributed to different conditions for purposes of calculating the refund or credit owed to the United States?

(a) All wounds, diseases or other medical conditions accepted by OWCP in connection with a single claim are treated as the same injury for the purpose of computing any required refund and any credit against future benefits in connection with the receipt of a recovery from a third party, except that an injury caused by medical malpractice in treating an injury covered under the FECA will be treated as a separate injury for purposes of section 8132.

(b) If an injury covered under the FECA is caused under circumstances creating a legal liability in more than one person, other than the United States, to pay damages, OWCP or SOL will determine whether recoveries received from one or more third parties

should be attributed to separate conditions for which compensation is payable in connection with a single FECA claim. If such an attribution is both practicable and equitable, as determined by OWCP or SOL, in its discretion, the conditions will be treated as separate injuries for purposes of calculating the refund and credit owed to the United States under section 8132.

FEDERAL GRAND AND PETIT JURORS

§ 10.725 When is a Federal grand or petit juror covered under the FECA?

(a) Federal grand and petit jurors are covered under the FECA when they are in performance of duty as a juror, which includes that time when a juror is:

(1) In attendance at court pursuant to a summons;

(2) In deliberation;

(3) Sequestered by order of a judge; or

(4) At a site, by order of the court, for the taking of a view.

(b) A juror is not considered to be in the performance of duty while traveling to or from home in connection with the activities enumerated in paragraphs (a) (1) through (4) of this section.

§ 10.726 When does a juror's entitlement to disability compensation begin?

Pursuant to 28 U.S.C. 1877, entitlement to disability compensation does not commence until the day after the date of termination of service as a juror.

§ 10.727 What is the pay rate of jurors for compensation purposes?

For the purpose of computing compensation payable for disability or death, a juror is deemed to receive pay at the minimum rate for Grade GS–2 of the General Schedule unless his or her actual pay as an ''employee'' of the United States while serving on court leave is higher, in which case the pay rate for compensation purposes is determined in accordance with 5 U.S.C. 8114.

PEACE CORPS VOLUNTEERS

§ 10.730 What are the conditions of coverage for Peace Corps volunteers and volunteer leaders injured while serving outside the United States?

(a) Any injury sustained by a volunteer or volunteer leader while he or she is located abroad shall be presumed to have been sustained in the performance of duty, and any illness contracted during such time shall be presumed to be proximately caused by the employment. However, this presumption will be rebutted by evidence that:

(1) The injury or illness was caused by the claimant's willful misconduct, intent to bring about the injury or death of self or another, or was proximately caused by the intoxication by alcohol or illegal drugs of the injured claimant; or

(2) The illness is shown to have preexisted the period of service abroad; or

(3) The injury or illness claimed is a manifestation of symptoms of, or consequent to, a pre-existing congenital defect or abnormality.

(b) If the presumption that an injury or illness was sustained in the performance of duty is rebutted as provided by paragraph (a) of this section, the claimant has the burden of proving by the submittal of substantial and probative evidence that such injury or illness was sustained in the performance of duty with the Peace Corps.

(c) If an injury or illness, or episode thereof, comes within one of the exceptions described in paragraph (a) (2) or (3) of this section, the claimant may nonetheless be entitled to compensation. This will be so provided he or she meets the burden of proving by the submittal of substantial, probative and rationalized medical evidence that the illness or injury was proximately caused by factors or conditions of Peace Corps service, or that it was materially aggravated, accelerated or precipitated by factors of Peace Corps service.

§ 10.731 What is the pay rate of Peace Corps volunteers and volunteer leaders for compensation purposes?

The pay rate for these claimants is defined as the pay rate in effect on the date following separation, provided

that the rate equals or exceeds the pay rate on the date of injury. It is defined in accordance with 5 U.S.C. 8142(a), not 8101(4).

NON-FEDERAL LAW ENFORCEMENT OFFICERS

§ 10.735 When is a non-Federal law enforcement officer (LEO) covered under the FECA?

(a) A law enforcement officer (officer) includes an employee of a State or local Government, the Governments of U.S. possessions and territories, or an employee of the United States pensioned or pensionable under sections 521–535 of Title 4, D.C. Code, whose functions include the activities listed in 5 U.S.C. 8191.

(b) Benefits are available to officers who are not ''employees'' under 5 U.S.C. 8101, and who are determined in the discretion of OWCP to have been engaged in the activities listed in 5 U.S.C. 8191 with respect to the enforcement of crimes against the United States. Individuals who only perform administrative functions in support of officers are not considered officers.

(c) Except as provided by 5 U.S.C. 8191 and 8192 and elsewhere in this part, the provisions of the FECA and of subparts A, B, and D through I of this part apply to officers.

§ 10.736 What are the time limits for filing a LEO claim?

OWCP must receive a claim for benefits under 5 U.S.C. 8191 within five years after the injury or death. This five-year limitation is not subject to waiver. The tolling provisions of 5 U.S.C. 8122(d) do not apply to these claims.

§ 10.737 How is a LEO claim filed, and who can file a LEO claim?

A claim for injury or occupational disease should be filed on Form CA–721; a death claim should be filed on Form CA–722. All claims should be submitted to the officer's employer for completion and forwarding to OWCP. A claim may be filed by the officer, the officer's survivor, or any person or association authorized to act on behalf of an officer or an officer's survivors.

§ 10.738 Under what circumstances are benefits payable in LEO claims?

(a) Benefits are payable when an officer is injured while apprehending, or attempting to apprehend, an individual for the commission of a Federal crime. However, either an actual Federal crime must be in progress or have been committed, or objective evidence (of which the officer is aware at the time of injury) must exist that a potential Federal crime was in progress or had already been committed. The actual or potential Federal crime must be an integral part of the criminal activity toward which the officer's actions are directed. The fact that an injury to an officer is related in some way to the commission of a Federal crime does not necessarily bring the injury within the coverage of the FECA. The FECA is not intended to cover officers who are merely enforcing local laws.

(b) For benefits to be payable when an officer is injured preventing, or attempting to prevent, a Federal crime, there must be objective evidence that a Federal crime is about to be committed. An officer's belief, unsupported by objective evidence, that he or she is acting to prevent the commission of a Federal crime will not result in coverage. Moreover, the officer's subjective intent, as measured by all available evidence (including the officer's own statements and testimony, if available), must have been directed toward the prevention of a Federal crime. In this context, an officer's own statements and testimony are relevant to, but do not control, the determination of coverage.

§ 10.739 What kind of objective evidence of a potential Federal crime must exist for coverage to be extended?

Based on the facts available at the time of the event, the officer must have an awareness of sufficient information which would lead a reasonable officer, under the circumstances, to conclude that a Federal crime was in progress, or was about to occur. This awareness need not extend to the precise particulars of the crime (the section of Title 18, United States Code, for example), but there must be sufficient

evidence that the officer was in fact engaged in actual or attempted apprehension of a Federal criminal or prevention of a Federal crime.

§ 10.740 In what situations will OWCP automatically presume that a law enforcement officer is covered by the FECA?

(a) Where an officer is detailed by a competent State or local authority to assist a Federal law enforcement authority in the protection of the President of the United States, or any other person actually provided or entitled to U.S. Secret Service protection, coverage will be extended.

(b) Coverage for officers of the U.S. Park Police and those officers of the Uniformed Division of the U.S. Secret Service who participate in the District of Columbia Retirement System is adjudicated under the principles set forth in paragraph (a) of this section, and does not extend to numerous tangential activities of law enforcement (for example, reporting to work, changing clothes). However, officers of the Non-Uniformed Division of the U.S. Secret Service who participate in the District of Columbia Retirement System are covered under the FECA during the performance of all official duties.

§ 10.741 How are benefits calculated in LEO claims?

(a) Except for continuation of pay, eligible officers and survivors are entitled to the same benefits as if the officer had been an employee under 5 U.S.C. 8101. However, such benefits may be reduced or adjusted as OWCP in its discretion may deem appropriate to reflect comparable benefits which the officer or survivor received or would have been entitled to receive by virtue of the officer's employment.

(b) For the purpose of this section, a comparable benefit includes any benefit that the officer or survivor is entitled to receive because of the officer's employment, including pension and disability funds, State workers' compensation payments, Public Safety Officers' Benefits Act payments, and State and local lump-sum payments. Health benefits coverage and proceeds of life insurance policies purchased by the employer are not considered to be comparable benefits.

(c) The FECA provides that, where an officer receives comparable benefits, compensation benefits are to be reduced proportionally in a manner that reflects the relative percentage contribution of the officer and the officer's employer to the fund which is the source of the comparable benefit. Where the source of the comparable benefit is a retirement or other system which is not fully funded, the calculation of the amount of the reduction will be based on a per capita comparison between the contribution by the employer and the contribution by all covered officers during the year prior to the officer's injury or death.

(d) The non-receipt of compensation during a period where a dual benefit (such as a lump-sum payment on the death of an officer) is being offset against compensation entitlement does not result in an adjustment of the respective benefit percentages of remaining beneficiaries because of a cessation of compensation under 5 U.S.C. 8133(c).

Subpart I—Information for Medical Providers

MEDICAL RECORDS AND BILLS

§ 10.800 What kind of medical records must providers keep?

Agency medical officers, private physicians and hospitals are required to keep records of all cases treated by them under the FECA so they can supply OWCP with a history of the injury, a description of the nature and extent of injury, the results of any diagnostic studies performed, the nature of the treatment rendered and the degree of any impairment and/or disability arising from the injury.

§ 10.801 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to injured employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 10.800. The physician or provider shall itemize the charges on the standard Health Insurance Claim Form, HCFA 1500 or

OWCP 1500, (for professional charges), the UB–92 (for hospitals), the Universal Claim Form (for pharmacies), or other form as warranted, and submit the form promptly to OWCP.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Health Care Financing Administration Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC), or the Revenue Center Code (RCC), with a brief narrative description. Where no code is applicable, a detailed description of services performed should be provided.

(c) The provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the ''International Classification of Disease, 9th Edition, Clinical Modification'' (ICD–9-CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the work-related condition is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for medical and surgical treatment or supplies promptly to OWCP on the Uniform Bill (UB–92). The provider shall identify each outpatient radiology service, outpatient pathology service and physical therapy service performed, using HCPCS/CPT codes with a brief narrative description. The charge for each individual service, or the total charge for all identical services, should also appear in the UB–92.

(ii) Other outpatient hospital services for which HCPCS/CPT codes exist shall also be coded individually using the coding scheme noted in this paragraph. Services for which there are no HCPCS/CPT codes available can be presented using the RCCs described in the ''National Uniform Billing Data Elements Specifications'', current edition. The provider shall also furnish the diagnostic code using the ICD–9–CM. If the outpatient hospital services include surgical and/or invasive procedures, the provider shall code each procedure using the proper CPT/HCPCS codes and furnishing the corresponding diagnostic codes using the ICD–9–CM.

(2) Pharmacies shall itemize charges for prescription medications, appliances, or supplies on the Universal Claim Form and submit them promptly to OWCP. Bills for prescription medications must include the NDC assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly to OWCP.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described and was necessary. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking reimbursement for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: be itemized on the Health Insurance Claim Form (for physicians), the UB–92 (for hospitals), or the Universal Claim Form (for pharmacies); contain the signature or signature stamp of the provider; and identify the procedures using HCPCS/CPT codes, RCCs, or NDCs. Otherwise, OWCP may return the bill to the provider for correction and resubmission.

§ 10.802 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or dental services, supplies or appliances due to an injury sustained in the performance of duty, he or she may submit an itemized bill on the Health Insurance Claim Form, HCFA 1500 or OWCP 1500, together with a medical report as provided in §10.800, to OWCP for consideration.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD–9–CM code and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service.

(2) The bill must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back) or a copy of the employee's credit card receipt.

(b) If services were provided by a hospital, pharmacy or nursing home, the employee should submit the bill in accordance with the provisions of §10.801(a). Any request for reimbursement must be accompanied by evidence, as described in paragraph (a) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) OWCP may waive the requirements of paragraphs (a) and (b) of this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) OWCP will not accept copies of bills for reimbursement unless they bear the original signature of the provider, with evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by the Director, as set forth in §10.805.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by the Director's schedule. If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider may request reconsideration of the fee determination as set forth in §10.812.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the appealed amount, OWCP shall initiate exclusion procedures as provided by §10.815.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may make reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

§10.803 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

MEDICAL FEE SCHEDULE

§10.805 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services furnished by physicians, hospitals and other providers for work-related injuries shall not exceed a maximum allowable charge for such service as determined by the Director, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 10.806 How are the maximum fees defined?

For professional medical services, the Director shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a value to procedures identified by Health Care Financing Administration Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs; and a monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

§ 10.807 How are payments for particular services calculated?

Payment for a procedure identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the relative values for that procedure by the geographic indices for services in that area and by the dollar amount assigned to one unit in that category of service.

(a) The ''locality'' which serves as a basis for the determination of average cost is defined by the Bureau of Census Metropolitan Statistical Areas. The Director shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by the Health Care Financing Administration (HCFA).

(b) The Director shall assign the relative value units (RVUs) published by HCFA to all services for which HCFA has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, the Director may develop and assign any RVUs that he or she considers appropriate. The geographic adjustment factor shall be that designated by Geographic Practice Cost Indices for Metropolitan Statistical Areas as devised for HCFA and as updated or revised by HCFA from time to time. The Director will devise conversion factors for each category of service, and in doing so may adapt HCFA conversion factors as appropriate using OWCP's processing experience and internal data.

(c) For example, if the unit values for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the dollar value assigned to one unit in that category of service (surgery) is $61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding geographical indices for the locality times the conversion factor. If the geographic indices for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$

$[2.45 + 3.44 + .56] \times \$61.20$

$6.45 \times \$61.20 = \$394.74$

§ 10.808 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, the Director may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for examinations performed under 5 U.S.C. 8123, and for other specially authorized services.

§ 10.809 How are payments for medicinal drugs determined?

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee.

(a) All prescription medications identified by National Drug Code (NDC) will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. The Director will establish the dispensing fee.

(b) The NDCs, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

§ 10.810 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Prospective Payment System (PPS) devised by HCFA (42 CFR parts 412, 413, 424, 485, and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All hospital discharges will be classified according to the DRGs prescribed by the HCFA in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by HCFA in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location (MSA) of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by HCFA to determine the specific rate for a hospital discharge under their PPS. The Director may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from HCFA's PPS on consideration of detailed medical reports and other evidence.

(4) The Director shall review the predetermined hospital rates at least once a year, and may adjust any or all components when he or she deems it necessary or appropriate.

(b) The Director shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when he or she deems it necessary or appropriate.

§ 10.811 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and other evidence. Where no code is supplied, OWCP may determine the code based on the narrative description of the procedure on the billing form and in associated medical reports. OWCP will pay no more than the maximum allowable fee for that procedure.

(b) If the charge submitted for a service supplied to an injured employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge.

§ 10.812 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by the Director may, within 30 days, request reconsideration of the fee determination.

(1) The provider should make such a request to the OWCP district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence that the procedure performed was incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board-certification in a specialty is not sufficient evidence of unusual qualifications to justify an exception. These are the only three circumstances which will justify reevaluation of the paid amount.

(2) A list of OWCP district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or from the Internet

at *www.dol.gov./dol/esa/owcp.htm.* Within 30 days of receiving the request for reconsideration, the OWCP district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the OWCP district office issues a decision which continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the OWCP district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted. This decision shall be final, and shall not be subject to further review.

§ 10.813 If OWCP reduces a fee, may a provider bill the claimant for the balance?

A provider whose fee for service is partially paid by OWCP as a result of the application of its fee schedule or other tests for reasonableness in accordance with this part shall not request reimbursement from the employee for additional amounts.

(a) Where a provider's fee for a particular service or procedure is lower to the general public than as provided by the schedule of maximum allowable charges, the provider shall bill at the lower rate. A fee for a particular service or procedure which is higher than the provider's fee to the general public for that same service or procedure will be considered a charge ''substantially in excess of such provider's customary charges'' for the purposes of §10.815(d).

(b) A provider whose fee for service is partially paid by OWCP as the result of the application of the schedule of maximum allowable charges and who collects or attempts to collect from the employee, either directly or through a collection agent, any amount in excess of the charge allowed by OWCP, and who does not cease such action or make appropriate refund to the employee within 60 days of the date of the decision of OWCP, shall be subject to the exclusion procedures provided by §10.815(h).

EXCLUSION OF PROVIDERS

§ 10.815 What are the grounds for excluding a provider from payment under the FECA?

A physician, hospital, or provider of medical services or supplies shall be excluded from payment under the FECA if such physician, hospital or provider has:

(a) Been convicted under any criminal statute of fraudulent activities in connection with any Federal or State program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;

(b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any Federal or State program referred to in paragraph (a) of this section;

(c) Knowingly made, or caused to be made, any false statement or misrepresentation of a material fact in connection with a determination of the right to reimbursement under the FECA, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a twelve-month period under this subpart containing charges which the Director finds to be substantially in excess of such provider's customary charges, unless the Director finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by the FECA and §10.800;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards; or

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP.

§ 10.816 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

(a) OWCP shall automatically exclude a physician, hospital, or provider of medical services or supplies who has been convicted of a crime described in § 10.815(a), or has been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in § 10.815(b).

(b) The exclusion applies to participating in the program and to seeking payment under the FECA for services performed after the date of the entry of the judgment of conviction or order of exclusion, suspension or resignation, as the case may be, by the court or agency concerned. Proof of the conviction, exclusion, suspension or resignation may consist of a copy thereof authenticated by the seal of the court or agency concerned.

§ 10.817 When are OWCP's exclusion procedures initiated?

Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has engaged in activities enumerated in paragraphs (c) through (h) of § 10.815, the Regional Director, after completion of inquiries he or she deems appropriate, may initiate procedures to exclude the provider from participation in the FECA program. For the purposes of this section, ''Regional Director'' may include any officer designated to act on his or her behalf.

§ 10.818 How is a provider notified of OWCP's intent to exclude him or her?

The Regional Director shall initiate the exclusion process by sending the provider a letter, by certified mail and with return receipt requested, which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which the Regional Director has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from participation in the FECA program without admitting or denying the allegations presented in the letter; or

(2) Request that the decision on exclusion be based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the Regional Director, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to answer (as described in § 10.819) the letter of intent within 30 calendar days of receipt, the Regional Director may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The name and address of the OWCP representative who shall be responsible for receiving the answer from the provider.

§ 10.819 What requirements must the provider's reply and OWCP's decision meet?

(a) The provider's answer shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to answer the letter of intent within 30 calendar days of receipt, the Regional Director may deem the allegations made therein to be true and may order exclusion of the provider.

(c) By arrangement with the official representative, the provider may inspect or request copies of information

in the record at any time prior to the Regional Director's decision.

(d) The Regional Director shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested. The decision shall advise the provider of his or her right to request, within 30 days of the date of the adverse decision, a formal hearing before an administrative law judge under the procedures set forth in §10.820. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

§10.820 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the official representative named under §10.818(f) and shall contain:

(a) A concise notice of the issues on which the provider desires to give evidence at the hearing;

(b) Any request for a more definite statement by OWCP;

(c) Any request for the presentation of oral argument or evidence; and

(d) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or Federal, State or local regulatory body.

§10.821 How are hearings assigned and scheduled?

(a) If the designated OWCP representative receives a timely request for hearing, the OWCP representative shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and Hearing Schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and Hearing Schedule shall include:

(1) A ruling on each item raised in the request for hearing;

(2) A schedule for the prompt disposition of all preliminary matters, including requests for more definite statements and for the certification of questions to advisory bodies; and

(3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The purpose of the designation of issues is to provide for an effective hearing process. The provider is entitled to be heard on any matter placed in issue by his or her response to the Notice of Intent to Exclude, and may designate ''all issues'' for purposes of hearing. However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses, or request the issuance of subpoenas or the certification of questions for an advisory opinion.

§10.822 How are subpoenas or advisory opinions obtained?

(a) The provider may apply to the administrative law judge for the issuance of subpoenas upon a showing of good cause therefor.

(b) A certification of a request for an advisory opinion concerning professional medical standards, medical ethics or medical regulation to a competent recognized or professional organization or Federal, State or local regulatory agency may be made:

(1) As to an issue properly designated by the provider, in the sound discretion of the administrative law judge, provided that the request will not unduly delay the proceedings;

(2) By OWCP on its own motion either before or after the institution of proceedings, and the results thereof shall be made available to the provider at the time that proceedings are instituted or, if after the proceedings are instituted, within a reasonable time after receipt. The opinion, if rendered by the organization or agency, is advisory only and not binding on the administrative law judge.

§10.823 How will the administrative law judge conduct the hearing and issue the recommended decision?

(a) To the extent appropriate, proceedings before the administrative law

judge shall be governed by 29 CFR part 18.

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the Notice and Response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

(c) All hearings shall be recorded and the original of the complete transcript shall become a permanent part of the official record of the proceedings.

(d) Pursuant to 5 U.S.C. 8126, the administrative law judge may:

(1) Issue subpoenas for and compel the attendance of witnesses within a radius of 100 miles;

(2) Administer oaths;

(3) Examine witnesses; and

(4) Require the production of books, papers, documents, and other evidence with respect to the proceedings.

(e) At the conclusion of the hearing, the administrative law judge shall issue a written decision and cause it to be served on all parties to the proceeding, their representatives and the Director.

§ 10.824 How can a party request review by the Director of the administrative law judge's recommended decision?

(a) Any party adversely affected or aggrieved by the decision of the administrative law judge may file a petition for discretionary review with the Director within 30 days after issuance of such decision. The administrative law judge's decision, however, shall be effective on the date issued and shall not be stayed except upon order of the Director.

(b) Review by the Director shall not be a matter of right but of the sound discretion of the Director.

(c) Petitions for discretionary review shall be filed only upon one or more of the following grounds:

(1) A finding or conclusion of material fact is not supported by substantial evidence;

(2) A necessary legal conclusion is erroneous;

(3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director;

(4) A substantial question of law, policy, or discretion is involved; or

(5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by any party shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) A statement in opposition to the petition for discretionary review may be filed, but such filing shall in no way delay action on the petition.

(f) If a petition is granted, review shall be limited to the questions raised by the petition.

(g) A petition not granted within 20 days after receipt of the petition is deemed denied.

(h) The decision of the Director shall be final with respect to the provider's participation in the program, and shall not be subject to further review by any court or agency.

§ 10.825 What are the effects of exclusion?

(a) OWCP shall give notice of the exclusion of a physician, hospital or provider of medical services or supplies to:

(1) All OWCP district offices;

(2) All Federal employers;

(3) The HCFA;

(4) The State or local authority responsible for licensing or certifying the excluded party; and

(5) All employees who are known to have had treatment, services or supplies from the excluded provider within

the six-month period immediately preceding the order of exclusion.

(b) Notwithstanding any exclusion of a physician, hospital, or provider of medical services or supplies under this subpart, OWCP shall not refuse an employee reimbursement for any otherwise reimbursable medical treatment, service or supply if:

(1) Such treatment, service or supply was rendered in an emergency by an excluded physician; or

(2) The employee could not reasonably have been expected to have known of such exclusion.

(c) An employee who is notified that his or her attending physician has been excluded shall have a new right to select a qualified physician.

§ 10.826 How can an excluded provider be reinstated?

(a) If a physician, hospital, or provider of medical services or supplies has been automatically excluded pursuant to § 10.816, the provider excluded will automatically be reinstated upon notice to OWCP that the conviction or exclusion which formed the basis of the automatic exclusion has been reversed or withdrawn. However, an automatic reinstatement shall not preclude OWCP from instituting exclusion proceedings based upon the underlying facts of the matter.

(b) A physician, hospital, or provider of medical services or supplies excluded from participation as a result of an order issued pursuant to this subpart may apply for reinstatement one year after the entry of the order of exclusion, unless the order expressly provides for a shorter period. An application for reinstatement shall be addressed to the Director for Federal Employees' Compensation, and shall contain a concise statement of the basis for the application. The application should be accompanied by supporting documents and affidavits.

(c) A request for reinstatement may be accompanied by a request for oral argument. Oral argument will be allowed only in unusual circumstances where it will materially aid the decision process.

(d) The Director for Federal Employees' Compensation shall order reinstatement only in instances where such reinstatement is clearly consistent with the goal of this subpart to protect the FECA program against fraud and abuse. To satisfy this requirement the provider must provide reasonable assurances that the basis for the exclusion will not be repeated.

PART 25—Compensation for Disability and Death of Noncitizen Federal Employees Outside the United States

Subpart A—General Provisions

Sec.

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AUTHORITY: 5 U.S.C. 301, 8137, 8145 and 8149; 1946 Reorganization Plan No. 2, sec. 3, 3 CFR 1943–1948 Comp., p. 1064; 60 Stat. 1095; Reorganization Plan No. 19 of 1950, sec. 1, 3 CFR 1943–1953 Comp., p. 1010; 64 Stat. 1271; Secretary's Order 5–96, 62 FR 107.

SOURCE: 63 FR 65340, Nov. 25, 1998, unless otherwise noted.

Subpart A—General Provisions

§ 25.1 How are claims of Federal employees who are neither citizens nor residents adjudicated?

This part describes how OWCP pays compensation under the FECA to employees of the United States who are neither citizens nor residents of the United States, any territory or Canada, as well as to any dependents of such employees. It has been determined that the compensation provided under the FECA is substantially disproportionate to the compensation for disability or death which is payable in similar cases under local law, regulation, custom or otherwise, in areas outside the United States, any territory or Canada. Therefore, with respect to the claims of such employees whose injury (or injury resulting in death) has occurred subsequent to December 7, 1941, or may occur, the regulations in this part shall apply.

§ 25.2 In general, what is the Director's policy regarding such claims?

(a) Pursuant to 5 U.S.C. 8137, the benefit features of local workers' compensation laws, or provisions in the nature of workers' compensation, in effect in areas outside the United States, any territory or Canada shall, effective as of December 7, 1941 and as recognized by the Director, be adopted and apply in the cases of employees of the United States who are neither citizens nor residents of the United States, any territory or Canada, unless a special schedule of compensation for injury or death has been established under this part for the particular locality, or for a class of employees in the particular locality.

(b) The benefit provisions adopted under paragraph (a) of this section are those dealing with money payments for injury and death (including medical benefits), as well as those dealing with services and purposes forming an integral part of the local plan, provided they are of a kind or character similar to services and purposes authorized by the FECA.

(1) Procedural provisions, designations of classes of beneficiaries in death cases, limitations (except those affecting amounts of benefit payments), and any other provisions not directly affecting the amounts of the benefit payments, in such local plans, shall not apply, but in lieu thereof the pertinent provisions of the FECA shall apply, unless modified in this section.

(2) However, the Director may at any time modify, limit or redesignate the class or classes of beneficiaries entitled to death benefits, including the designation of persons, representatives or groups entitled to payment under local statute or custom whether or not included in the classes of beneficiaries otherwise specified by this subchapter.

(c) Compensation in all cases of such employees paid and closed prior to January 4, 1999 shall be deemed compromised and paid under 5 U.S.C. 8137. In all other cases, compensation may be adjusted to conform with the regulations in this part, or the beneficiary may by compromise or agreement with the Director have compensation continued on the basis of a previous adjustment of the claim.

(d) Persons employed in a country or area having no well-defined workers' compensation benefits structure shall be accorded the benefits provided—either by local law or special schedule—in a nearby country as determined by the Director. In selecting the benefit structure to be applied, equity and administrative ease will be given consideration, as well as local custom.

(e) Compensation for disability and death of non-citizens outside the United States under this part, whether paid under local law or special schedule, shall in no event exceed that generally payable under the FECA.

§ 25.3 What is the authority to settle and pay such claims?

In addition to the authority to receive, process and pay claims, when delegated such representative or agency receiving delegation of authority shall, in respect to cases adjudicated under this part, and when so authorized by the Director, have authority to make lump-sum awards (in the manner prescribed by 5 U.S.C. 8135) whenever such authorized representative shall deem such settlement to be for the best interest of the United States, and to compromise and pay claims for any benefits provided for under this part,

including claims in which there is a dispute as to questions of fact or law. The Director shall, in instructions to the particular representative concerned, establish such procedures in respect to action under this section as he or she may deem necessary, and may specify the scope of any administrative review of such action.

§ 25.4 What type of evidence is required to establish a claim under this part?

Claims of employees of the United States who are neither citizens nor residents of the United States, any territory or Canada, if otherwise compensable, shall be approved only upon evidence of the following nature without regard to the date of injury or death for which claim is made:

(a) Appropriate certification by the Federal employing establishment; or

(b) An armed service's casualty or medical record; or

(c) Verification of the employment and casualty by military personnel; or

(d) Recommendation of an armed service's ''Claim Service'' based on investigations conducted by it.

§ 25.5 What special rules does OWCP apply to claims of third and fourth country nationals?

(a) *Definitions.* A ''third country national'' is a person who is neither a citizen nor resident of the United States who is hired by the United States in the person's country of citizenship or residence for employment in another foreign country, or in a possession or territory of the United States. A ''fourth country national'' is a person who is neither a citizen nor resident of either the country of hire or the place of employment, but who otherwise meets the definition of third country national. ''Benefits applicable to local hires'' are the benefits provided in this part by local law or special schedule, as determined by the Director. With respect to a United States territory or possession, ''local law'' means only the law of the particular territory or possession.

(b) *Benefits payable.* Third and fourth country nationals shall be paid the benefits applicable to local hires in the country of hire or the place of employment, whichever benefits are greater, provided that all benefits payable on account of one injury must be paid under the same benefit structure.

(1) Where no well-defined workers' compensation benefits structure is provided in either the country of hire or the place of employment, the provisions of § 25.2(d) shall apply.

(2) Where equitable considerations as determined by the Director so warrant, a fourth country national may be awarded benefits applicable to local hires in his or her home country.

§ 25.6 How does OWCP adjudicate claims of non-citizen residents of possessions?

An employee who is a *bona fide* permanent resident of any United States possession, territory, commonwealth or trust territory will receive the full benefits of the FECA, as amended, except that the application of the minimum benefit provisions provided therein shall be governed by the restrictions set forth in 5 U.S.C. 8138.

Subpart B—The Special Schedule of Compensation

§ 25.100 How is compensation for disability paid?

Compensation for disability shall be paid to the employee as follows:

(a) *Permanent total disability.* In cases of permanent total disability, 66⅔ percent of the monthly pay during the period of such disability.

(b) *Temporary total disability.* In cases of temporary total disability, 66⅔ percent of the monthly pay during the period of such disability.

(c) *Permanent partial disability.* In cases of permanent partial disability, 66⅔ percent of the monthly pay, for the following losses and periods:

(1) Arm lost: 280 weeks' compensation.

(2) Leg lost: 248 weeks' compensation.

(3) Hand lost: 212 weeks' compensation.

(4) Foot lost: 173 weeks' compensation.

(5) Eye lost: 140 weeks' compensation.

(6) Thumb lost: 51 weeks' compensation.

(7) First finger lost: 28 weeks' compensation.

(8) Great toe lost: 26 weeks' compensation.

(9) Second finger lost: 18 weeks' compensation.

(10) Third finger lost: 17 weeks' compensation.

(11) Toe, other than great toe, lost: 8 weeks' compensation.

(12) Fourth finger lost: 7 weeks' compensation.

(13) Loss of hearing: One ear, 52 weeks' compensation; both ears, 200 weeks' compensation.

(14) Phalanges: Compensation for loss of more than one phalanx of a digit shall be the same as for the loss of the entire digit. Compensation for loss of the first phalanx shall be one-half of the compensation for the loss of the entire digit.

(15) Amputated arm or leg: Compensation for an arm or a leg, if amputated at or above the elbow or the knee, shall be the same as for the loss of the arm or leg; but, if amputated between the elbow and the wrist, or between the knee and the ankle, the compensation shall be the same as for the loss of the hand or the foot.

(16) Binocular vision or percent of vision: Compensation for loss of binocular vision, or for 80 percent or more of the vision of an eye shall be the same as for the loss of the eye.

(17) Two or more digits: Compensation for loss of two or more digits, one or more phalanges of two or more digits of a hand or foot may be proportioned to the loss of use of the hand or foot occasioned thereby, but shall not exceed the compensation for the loss of a hand or a foot.

(18) Total loss of use: Compensation for a permanent total loss of use of a member shall be the same as for loss of the member.

(19) Partial loss or partial loss of use: Compensation for permanent partial loss or loss of use of a member may be for proportionate loss of use of the member.

(20) Consecutive awards: In any case in which there shall be a loss or loss of use of more than one member or parts of more than one member set forth in paragraphs (c) (1) through (19) of this section, but not amounting to permanent total disability, the award of compensation shall be for the loss or loss of use of each such member or part thereof, which awards shall run consecutively, except that where the injury affects only two or more digits of the same hand or foot, paragraph (c)(17) of this section shall apply.

(21) Other cases: In all other cases within this class of disability the compensation during the continuance of disability shall be that proportion of compensation for permanent total disability, as determined under paragraph (a) of this section, which is equal in percentage to the degree or percentage of physical impairment caused by the disability.

(22) Compensation under paragraphs (c) (1) through (21) of this section for permanent partial disability shall be in addition to any compensation for temporary total or temporary partial disability under this section, and awards for temporary total, temporary partial, and permanent partial disability shall run consecutively.

(d) *Temporary partial disability.* In cases of temporary partial disability, during the period of disability, that proportion of compensation for temporary total disability, as determined under paragraph (b) of this section, which is equal in percentage to the degree or percentage of physical impairment caused by the disability.

§ 25.101 How is compensation for death paid?

If the disability causes death, the compensation shall be payable in the amount and to or for the benefit of the following persons:

(a) To the undertaker or person entitled to reimbursement, reasonable funeral expenses not exceeding $200.

(b) To the surviving spouse, if there is no child, 35 percent of the monthly pay until his or her death or remarriage.

(c) To the surviving spouse, if there is a child, the compensation payable under paragraph (b) of this section, and in addition thereto 10 percent of the monthly wage for each child, not to exceed a total of 66⅔ percent for such surviving spouse and children. If a child has a guardian other than the surviving spouse, the compensation payable on account of such child shall

be paid to such guardian. The compensation of any child shall cease when he or she dies, marries or reaches the age of 18 years, or if over such age and incapable of self-support, becomes capable of self-support.

(d) To the children, if there is no surviving spouse, 25 percent of the monthly pay for one child and 10 percent thereof for each additional child, not to exceed a total of 66⅔ percent thereof, divided among such children share and share alike. The compensation of each child shall be paid until he or she dies, marries or reaches the age of 18, or if over such age and incapable of self-support, becomes capable of self-support. The compensation of a child under legal age shall be paid to its guardian, if there is one, otherwise to the person having the custody or care of such child, for such child, as the Director in his or her discretion shall determine.

(e) To the parents, if one is wholly dependent for support upon the deceased employee at the time of his or her death and the other is not dependent to any extent, 25 percent of the monthly pay; if both are wholly dependent, 20 percent thereof to each; if one is or both are partly dependent, a proportionate amount in the discretion of the Director. The compensation to a parent or parents in the percentages specified shall be paid if there is no surviving spouse or child, but if there is a surviving spouse or child, there shall be paid so much of such percentages for a parent or parents as, when added to the total of the percentages of the surviving spouse and children, will not exceed a total of 66⅔ percent of the monthly pay.

(f) To the brothers, sisters, grandparents and grandchildren, if one is wholly dependent upon the deceased employee for support at the time of his or her death, 20 percent of the monthly pay to such dependent; if more than one are wholly dependent, 30 percent of such pay, divided among such dependents share and share alike; if there is no one of them wholly dependent, but one or more are partly dependent, 10 percent of such pay divided among such dependents share and share alike. The compensation to such beneficiaries shall be paid if there is no surviving spouse, child or dependent parent. If there is a surviving spouse, child or dependent parent, there shall be paid so much of the above percentages as, when added to the total of the percentages payable to the surviving spouse, children and dependent parents, will not exceed a total of 66⅔ percent of such pay.

(g) The compensation of each beneficiary under paragraphs (e) and (f) of this section shall be paid until he or she, if a parent or grandparent, dies, marries or ceases to be dependent, or, if a brother, sister or grandchild, dies, marries or reaches the age of 18 years, or if over such age and incapable of self-support, becomes capable of self-support. The compensation of a brother, sister or grandchild under legal age shall be paid to his or her guardian, if there is one, otherwise to the person having the custody or care of such person, for such person, as the Director in his or her discretion shall determine.

(h) Upon the cessation of any person's compensation for death under this subpart, the compensation of any remaining person entitled to continuing compensation in the same case shall be adjusted, so that the continuing compensation shall be at the same rate such person would have received had no award been made to the person whose compensation ceased.

(i) In cases where there are two or more classes of persons entitled to compensation for death under this subpart, and the apportionment of such compensation as provided in this section would result in injustice, the Director may in his or her discretion modify the apportionments to meet the requirements of the case.

§ 25.102 What general provisions does OWCP apply to the Special Schedule?

(a) The definitions of terms in the FECA, as amended, shall apply to terms used in this subpart.

(b) The provisions of the FECA, unless modified by this subpart or otherwise inapplicable, shall be applied whenever possible in the application of this subpart.

(c) The provisions of the regulations for the administration of the FECA, as amended or supplemented from time to time by instructions applicable to this

subpart, shall apply in the administration of compensation under this subpart, whenever they can reasonably be applied.

Subpart C—Extensions of the Special Schedule of Compensation

§ 25.200 How is the Special Schedule applied for employees in the Republic of the Philippines?

(a) *Modified special schedule of compensation.* Except for injury or death of direct-hire employees of the U.S. Military Forces covered by the Philippine Medical Care Program and the Employees' Compensation Program pursuant to the agreement signed by the United States and the Republic of the Philippines on March 10, 1982 who are also members of the Philippine Social Security System, the special schedule of compensation established in subpart B of this part shall apply, with the modifications or additions specified in paragraphs (b) through (k) of this section, in the Republic of the Philippines, to injury or death occurring on or after July 1, 1968, with the following limitations:

(1) *Temporary disability.* Benefits for payments accruing on and after July 1, 1969, for injuries causing temporary disability and which occurred on and after July 1, 1968, shall be payable at the rates in the special schedule as modified in this section.

(2) *Permanent disability and death.* Benefits for injuries occurring on and after July 1, 1968, which cause permanent disability or death, shall be payable at the rates specified in the special schedule as modified in this section for all awards not paid in full before July 1, 1969, and any award paid in full prior to July 1, 1969: Provided, that application for adjustment is made, and the adjustment will result in additional benefits of at least $10. In the case of injuries or death occurring on or after December 8, 1941 and prior to July 1, 1968, the special schedule as modified in this section may be applied to prospective awards for permanent disability or death, provided that the monthly and aggregate maximum provisions in effect at the time of injury or death shall prevail. These maxima are $50 and $4,000, respectively.

(b) *Death benefits.* 400 weeks' compensation at two-thirds of the weekly wage rate, shared equally by the eligible survivors in the same class.

(c) *Death beneficiaries.* Benefits are payable to the survivors in the following order of priority (all beneficiaries in the highest applicable classes are entitled to share equally):

(1) Surviving spouse and unmarried children under 18, or over 18 and totally incapable of self-support.

(2) Dependent parents.

(3) Dependent grandparents.

(4) Dependent grandchildren, brothers and sisters who are unmarried and under 18, or over 18 and totally incapable of self-support.

(d) *Burial allowance.* 14 weeks' wages or $400, whichever is less, payable to the eligible survivor(s), regardless of the actual expense. If there is no eligible survivor, actual burial expenses may be paid or reimbursed, in an amount not to exceed what would be paid to an eligible survivor.

(e) *Permanent total disability.* 400 weeks' compensation at two-thirds of the weekly wage rate.

(f) *Permanent partial disability.* Where applicable, the compensation provided in paragraphs (c) (1) through (19) of § 25.100, subject to an aggregate limitation of 400 weeks' compensation. In all other cases, provided for permanent total disability that proportion of the compensation (paragraph (e) of this section) which is equivalent to the degree or percentage of physical impairment caused by the disability.

(g) *Temporary partial disability.* Two-thirds of the weekly loss of wage-earning capacity.

(h) *Compensation period for temporary disability.* Compensation for temporary disability is payable for a maximum period of 80 weeks.

(i) *Maximum compensation.* The total aggregate compensation payable in any case, for injury or death or both, shall not exceed $8,000, exclusive of medical costs and burial allowance. The weekly rate of compensation for disability or death shall not exceed $35.

(j) *Method of payment.* Only compensation for temporary disability

shall be payable periodically. Compensation for permanent disability and death shall be payable in full at the time the extent of entitlement is established.

(k) *Exceptions.* The Director in his or her discretion may make exceptions to the regulations in this section by:

(1) Reapportioning death benefits, for the sake of equity.

(2) Excluding from consideration potential death beneficiaries who are not available to receive payment.

(3) Paying compensation for permanent disability or death on a periodic basis, where this method of payment is considered to be in the best interest of the beneficiary.

§ 25.201 How is the Special Schedule applied for employees in Australia?

(a) The special schedule of compensation established by subpart B of this part shall apply in Australia with the modifications or additions specified in paragraph (b) of this section, as of December 8, 1941, in all cases of injury (or death from injury) which occurred between December 8, 1941 and December 31, 1961, inclusive, and shall be applied retrospectively in all such cases of injury (or death from injury). Compensation in all such cases pending as of July 15, 1946, shall be readjusted accordingly, with credit taken in the amount of compensation paid prior to such date. Refund of compensation shall not be required if the amount of compensation paid in any such case, otherwise than through fraud, misrepresentation or mistake, and prior to July 15, 1946, exceeds the amount provided for under this paragraph, and such case shall be deemed compromised and paid under 5 U.S.C. 8137.

(b) The total aggregate compensation payable in any case under paragraph (a) of this section, for injury or death or both, shall not exceed the sum of $4,000, exclusive of medical costs. The maximum monthly rate of compensation in any such case shall not exceed the sum of $50.

(c) The benefit amounts payable under the provisions of the Commonwealth Employees' Compensation Act of 1930–1964, Australia, shall apply as of January 1, 1962, in Australia, as the exclusive measure of compensation in cases of injury (or death from injury) according on and after January 1, 1962, and shall be applied retrospectively in all such cases, occurring on and after such date: Provided, that the compensation payable under the provisions of this paragraph shall in no event exceed that payable under the FECA.

§ 25.202 How is the Special Schedule applied for Japanese seamen?

(a) The special schedule of compensation established by subpart B of this part shall apply as of November 1, 1971, with the modifications or additions specified in paragraphs (b) through (i) of this section, to injuries sustained outside the continental United States or Canada by direct-hire Japanese seamen who are neither citizens nor residents of the United States or Canada and who are employed by the Military Sealift Command in Japan.

(b) *Temporary total disability.* Weekly compensation shall be paid at 75 percent of the weekly wage rate.

(c) *Temporary partial disability.* Weekly compensation shall be paid at 75 percent of the weekly loss of wage-earning capacity.

(d) *Permanent total disability.* Compensation shall be paid in a lump sum equivalent to 360 weeks' wages.

(e) *Permanent partial disability.* (1) The provisions of § 25.100 shall apply to the types of permanent partial disability listed in paragraphs (c) (1) through (19) of that section: Provided that weekly compensation shall be paid at 75 percent of the weekly wage rate and that the number of weeks allowed for specified losses shall be changed as follows:

(i) Arm lost: 312 weeks.

(ii) Leg lost: 288 weeks.

(iii) Hand lost: 244 weeks.

(iv) Foot lost: 205 weeks.

(v) Eye lost: 160 weeks.

(vi) Thumb lost: 75 weeks.

(vii) First finger lost: 46 weeks.

(viii) Second finger lost: 30 weeks.

(ix) Third finger lost: 25 weeks.

(x) Fourth finger lost: 15 weeks.

(xi) Great toe lost: 38 weeks.

(xii) Toe, other than great toe lost: 16 weeks.

(2) In all other cases, that proportion of the compensation provided for permanent total disability in paragraph (d) of this section which is equivalent

to the degree or percentage of physical impairment caused by the injury.

(f) *Death.* If there are two or more eligible survivors, compensation equivalent to 360 weeks' wages shall be paid to the survivors, share and share alike. If there is only one eligible survivor, compensation equivalent to 300 weeks' wages shall be paid. The following survivors are eligible for death benefits:

(1) Spouse who lived with or was dependent upon the employee.

(2) Unmarried children under 21 who lived with or were dependent upon the employee.

(3) Adult children who were dependent upon the employee by reason of physical or mental disability.

(4) Dependent parents, grandparents and grandchildren.

(g) *Burial allowance.* $1,000 payable to the eligible survivor(s), regardless of actual expenses. If there are no eligible survivors, actual expenses may be paid or reimbursed, up to $1,000.

(h) *Method of payment.* Only compensation for temporary disability shall be payable periodically, as entitlement accrues. Compensation for permanent disability and death shall be payable in a lump sum.

(i) *Maxima.* In all cases, the maximum weekly benefit shall be $130. Also, except in cases of permanent total disability and death, the aggregate maximum compensation payable for any injury shall be $40,000.

(j) *Prior injury.* In cases where injury or death occurred prior to November 1, 1971, benefits will be paid in accordance with regulations promulgated, contained in 20 CFR parts 1–399, edition revised as of January 1, 1971.

§ 25.203 How is the Special Schedule applied to non-resident aliens in the Territory of Guam?

(a) The special schedule of compensation established by subpart B of this part shall apply, with the modifications or additions specified in paragraphs (b) through (k) of this section, to injury or death occurring on or after July 1, 1971 in the Territory of Guam to non-resident alien employees recruited in foreign countries for employment by the military departments in the Territory of Guam. However, the Director may, in his or her discretion, adopt the benefit features and provisions of local workers' compensation law as provided in subpart A of this part, or substitute the special schedule in subpart B of this part or other modifications of the special schedule in this subpart C, if such adoption or substitution would be to the advantage of the employee or his or her beneficiary. This schedule shall not apply to any employee who becomes a permanent resident in the Territory of Guam prior to the date of his or her injury or death.

(b) *Death benefits.* 400 weeks' compensation at two-thirds of the weekly wage rate, shared equally by the eligible survivors in the same class.

(c) *Death beneficiaries.* Beneficiaries of death benefits shall be determined in accordance with the laws or customs of the country of recruitment.

(d) *Burial allowance.* 14 weeks' wages or $400, whichever is less, payable to the eligible survivor(s), regardless of the actual expense. If there is no eligible survivor, actual burial expenses may be paid or reimbursed, in an amount not to exceed what would be paid to an eligible survivor.

(e) *Permanent total disability.* 400 weeks' compensation at two-thirds of the weekly wage rate.

(f) *Permanent partial disability.* Where applicable, the compensation provided in paragraphs (c) (1) through (19) of § 25.100, subject to an aggregate limitation of 400 weeks' compensation. In all other cases, that proportion of the compensation provided for permanent total disability (paragraph (e) of this section) which is equivalent to the degree or percentage of physical impairment caused by the disability.

(g) *Temporary partial disability.* Two-thirds of the weekly loss of wage-earning capacity.

(h) *Compensation period for temporary disability.* Compensation for temporary disability is payable for a maximum period of 80 weeks.

(i) *Maximum compensation.* The total aggregate compensation payable in any case, for injury or death or both, shall not exceed $24,000, exclusive of medical costs and burial allowance. The weekly rate of compensation for disability or death shall not exceed $70.

(j) *Method of payment.* Compensation for temporary disability shall be payable periodically. Compensation for permanent disability and death shall be payable in full at the time the extent of entitlement is established.

(k) *Exceptions.* The Director may in his or her discretion make exception to the regulations in this section by:

(1) Reapportioning death benefits for the sake of equity.

(2) Excluding from consideration potential beneficiaries of a deceased employee who are not available to receive payment.

(3) Paying compensation for permanent disability or death on a periodic basis, where this method of payment is considered to be in the best interest of the employee or his or her beneficiary(ies).

SUBCHAPTER C—ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000

PART 30—CLAIMS FOR COMPENSATION UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000, AS AMENDED

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SOURCE: 71 FR 78534, Dec. 29, 2006, unless otherwise noted.

Subpart A—General Provisions

INTRODUCTION

§ 30.0 What are the provisions of EEOICPA, in general?

Part B of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), 42 U.S.C. 7384 *et seq.*, provides for the payment of compensation benefits to covered Part B employees and, where applicable, survivors of such employees, of the United States Department of Energy (DOE), its predecessor agencies and certain of its contractors and subcontractors. Part B also provides for the payment of supplemental compensation benefits to other covered Part B employees who have already been found eligible for benefits under section 5 of the Radiation Exposure Compensation Act, as amended (RECA), 42 U.S.C. 2210 note, and where applicable, survivors of such persons. Part E of the Act provides for the payment of compensation benefits to covered Part E employees and, where applicable, survivors of such employees. The regulations in this part describe the rules governing filing, processing, and paying claims for benefits under both Part B and Part E of EEOICPA.

(a) Part B of EEOICPA provides for the payment of either lump-sum monetary compensation for the disability of a covered Part B employee due to an occupational illness or for monitoring for beryllium sensitivity, as well as for medical and related benefits for such illness. Part B also provides for the payment of monetary compensation for the disability of a covered Part B employee to specified survivors if the employee is deceased at the time of payment.

(b) Part E of EEOICPA provides for the payment of monetary compensation for the established wage-loss and/or impairment of a covered Part E employee due to a covered illness, and for medical and related benefits for such covered illness. Part E also provides for

the payment of monetary compensation for the death (and established wage-loss, where applicable) of a covered Part E employee to specified survivors if the covered Part E employee is deceased at the time of payment.

(c) All types of benefits and conditions of eligibility listed in this section are subject to the provisions of EEOICPA and this part.

§ 30.1 What rules govern the administration of EEOICPA and this chapter?

In accordance with EEOICPA, Executive Order 13179 and Secretary's Order No. 4–2001, the primary responsibility for administering the Act, except for those activities assigned to the Secretary of Health and Human Services (HHS), the Secretary of Energy and the Attorney General, has been delegated to the Assistant Secretary of Labor for Employment Standards. The Assistant Secretary, in turn, has delegated the responsibility for administering the Act to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director of OWCP and his or her designees have the exclusive authority to administer, interpret and enforce the provisions of the Act.

§ 30.2 In general, how have the tasks associated with the administration of EEOICPA claims process been assigned?

(a) In E.O. 13179, the President assigned the tasks associated with administration of the EEOICPA claims process among the Secretaries of Labor, HHS and Energy, and the Attorney General. In light of the fact that the Secretary of Labor has been assigned primary responsibility for administering EEOICPA, almost the entire claims process is within the exclusive control of OWCP. This means that all claimants file their claims with OWCP, and OWCP is responsible for granting or denying compensation under the Act (see §§ 30.100 through 30.102). OWCP also provides assistance to claimants and potential claimants by providing information regarding eligibility and other program requirements, including information on completing claim forms and the types and availability of medical testing and diagnostic services related to occupational illnesses under Part B of the Act and covered illnesses under Part E of the Act. In addition, OWCP provides an administrative review process for claimants who disagree with its recommended and final adverse decisions on claims of entitlement (see §§ 30.300 through 30.320).

(b) However, HHS has exclusive control of the portion of the claims process under which it provides reconstructed doses for certain radiogenic cancer claims (see § 30.115). HHS also has exclusive control of the process for designating classes of employees to be added to the Special Exposure Cohort under Part B of the Act, and has promulgated regulations governing that process at 42 CFR part 83. Finally, HHS has promulgated regulations at 42 CFR part 81 that set out guidelines that OWCP follows when it assesses the compensability of an employee's radiogenic cancer (see § 30.213). DOE and DOJ must, among other things, notify potential claimants and submit evidence that OWCP deems necessary for its adjudication of claims under EEOICPA (see §§ 30.105, 30.112, 30.206, 30.212 and 30.221).

§ 30.3 What do these regulations contain?

This part 30 sets forth the regulations governing administration of all claims that are filed with OWCP, except to the extent specified in certain provisions. Its provisions are intended to assist persons seeking benefits under EEOICPA, as well as personnel in the various federal agencies and DOL who process claims filed under EEOICPA or who perform administrative functions with respect to EEOICPA. The various subparts of this part contain the following:

(a) Subpart A: The general statutory and administrative framework for processing claims under both Parts B and E of EEOICPA. It contains a statement of purpose and scope, together with definitions of terms, information regarding the disclosure of OWCP records, and a description of rights and penalties involving EEOICPA claims, including convictions for fraud.

(b) Subpart B: The rules for filing claims for entitlement under

EEOICPA. It also addresses general standards regarding necessary evidence and the burden of proof, descriptions of basic forms and special procedures for certain cancer claims.

(c) Subpart C: The eligibility criteria for occupational illnesses and covered illnesses compensable under Parts B and E of EEOICPA, respectively.

(d) Subpart D: The rules governing the adjudication process leading to recommended and final decisions on claims for entitlement filed under Parts B and E of EEOICPA. It also describes the hearing and reopening processes.

(e) Subpart E: The rules governing medical care, second opinion and referee medical examinations and impairment evaluations directed by OWCP as part of its adjudication of entitlement, and medical reports and records in general. It also addresses the kinds of medical treatment that may be authorized and how medical bills are paid.

(f) Subpart F: The rules relating to the payment of monetary compensation available under Parts B and E of EEOICPA. It includes provisions on medical monitoring for beryllium sensitivity, on the identification, processing and recovery of overpayments of compensation, and on the maximum aggregate amount of compensation payable under Part E.

(g) Subpart G: The rules concerning the representation of claimants in connection with the administrative adjudication of claims before OWCP, subrogation of the United States, the effect of tort suits against beryllium vendors and atomic weapons employers, and the coordination of benefits under Part E of EEOICPA with state workers' compensation benefits for the same covered illness.

(h) Subpart H: Information for medical providers. It includes rules for medical reports, medical bills, and the OWCP medical fee schedule, as well as the provisions for exclusion of medical providers.

(i) Subpart I: The rules relating to the adjudication of alleged periods of wage-loss of covered Part E employees. It also includes provisions on the use by OWCP of Social Security Administration earnings information and certain medical evidence to establish compensable wage-loss.

(j) Subpart J: The rules relating to the adjudication of alleged permanent impairment due to the exposure of covered Part E employees to toxic substances. It includes provisions relating to the medical evaluation of ratable impairments, the rating of progressive conditions, and qualifications of physicians.

DEFINITIONS

§ 30.5 What are the definitions used in this part?

(a) *Act* or *EEOICPA* means the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (42 U.S.C. 7384 *et seq.*).

(b) *Atomic weapon* means any device utilizing atomic energy, exclusive of the means for transporting or propelling the device (where such means is a separable and divisible part of the device), the principle purpose of which is for use as, or for development of, a weapon, a weapon prototype, or a weapon test device.

(c) *Atomic weapons employee* means:

(1) An individual employed by an atomic weapons employer during a period when the employer was processing or producing, for the use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; or

(2)(i) An individual employed at a facility that the National Institute for Occupational Safety and Health (NIOSH) reported had a potential for significant residual contamination outside of the period described in paragraph (c)(1) of this section;

(ii) By the atomic weapons employer that owned the facility referred to in paragraph (c)(2)(i) of this section, or a subsequent owner or operator of such facility; and

(iii) During a period reported by NIOSH, in its report dated October 2003 and titled ''Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities,'' or any update to that report, to have a potential for significant residual radioactive contamination.

(d) *Atomic weapons employer* means any entity, other than the United States, that:

(1) Processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and

(2) Is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program.

(e) *Atomic weapons employer facility* means any facility, owned by an atomic weapons employer, that:

(1) Is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling; and

(2) Is designated as such in the list periodically published in the FEDERAL REGISTER by DOE.

(f) *Attorney General* means the Attorney General of the United States or the United States Department of Justice (DOJ).

(g) *Benefit* or *Compensation* means the money the Department pays to or on behalf of either a covered Part B employee under Part B, or a covered Part E employee under Part E, from the Energy Employees Occupational Illness Compensation Fund. However, the term ''compensation'' used in section 7385f(b) of EEOICPA (restricting entitlement to only one payment of compensation under Part B) means only the payments specified in section 7384s(a)(1) and in section 7384u(a). Except as used in section 7385f(b), these two terms also include any other amounts paid out of the Fund for such things as medical treatment, monitoring, examinations, services, appliances and supplies as well as for transportation and expenses incident to the securing of such medical treatment, monitoring, examinations, services, appliances, and supplies.

(h) *Beryllium sensitization or sensitivity* means that the individual has an abnormal beryllium lymphocyte proliferation test (LPT) performed on either blood or lung lavage cells.

(i) *Beryllium vendor* means the specific corporations and named predecessor corporations listed in section 7384l(6) of the Act and any of the facilities designated as such in the list periodically published in the FEDERAL REGISTER by DOE.

(j) *Chronic silicosis* means a non-malignant lung disease if:

(1) The initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years; and

(2) A written diagnosis of silicosis is made by a medical doctor and is accompanied by:

(i) A chest radiograph, interpreted by an individual certified by NIOSH as a B reader, classifying the existence of pneumoconioses of category 1/0 or higher; or

(ii) Results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(iii) Lung biopsy findings consistent with silicosis.

(k) *Claim* means a written assertion to OWCP of an individual's entitlement to benefits under EEOICPA, submitted in a manner authorized by this part.

(l) *Claimant* means the individual who is alleged to satisfy the criteria for compensation under the Act.

(m) *Compensation fund* or *fund* means the fund established on the books of the Treasury for payment of benefits and compensation under the Act.

(n) *Contemporaneous record* means any document created at or around the time of the event that is recorded in the document.

(o) *Covered beryllium illness* means any of the following:

(1) Beryllium sensitivity as established by an abnormal LPT performed on either blood or lung lavage cells.

(2) Established chronic beryllium disease (see § 30.207(c)).

(3) Any injury, illness, impairment, or disability sustained as a consequence of a covered beryllium illness referred to in paragraphs (o)(1) or (2) of this section.

(p) *Covered Part E employee* means, under Part E of the Act, a Department of Energy contractor employee or a RECA section 5 uranium worker who has been determined by OWCP to have contracted a covered illness (see paragraph (r) of this section) through exposure at a Department of Energy facility or a RECA section 5 facility, as appropriate.

(q) *Covered Part B employee* means, under Part B of the Act, a covered beryllium employee (see § 30.205), a covered employee with cancer (see § 30.210(a)), a covered employee with chronic silicosis (see § 30.220), or a covered uranium employee (see paragraph (s) of this section).

(r) *Covered illness* means, under Part E of the Act relating to exposures at a DOE facility or a RECA section 5 facility, an illness or death resulting from exposure to a toxic substance.

(s) *Covered uranium employee* means, under Part B of the Act, an individual who has been determined by DOJ to be entitled to an award under section 5 of RECA, whether or not the individual was the employee or the deceased employee's survivor.

(t) *Current or former employee as defined in 5 U.S.C. 8101(1)* as used in § 30.205(a)(1) means an individual who fits within one of the following listed groups:

(1) A civil officer or employee in any branch of the Government of the United States, including an officer or employee of an instrumentality wholly owned by the United States;

(2) An individual rendering personal service to the United States similar to the service of a civil officer or employee of the United States, without pay or for nominal pay, when a statute authorizes the acceptance or use of the service, or authorizes payment of travel or other expenses of the individual;

(3) An individual, other than an independent contractor or individual employed by an independent contractor, employed on the Menominee Indian Reservation in Wisconsin in operations conducted under a statute relating to tribal timber and logging operations on that reservation;

(4) An individual appointed to a position on the office staff of a former President; or

(5) An individual selected and serving as a Federal petit or grand juror.

(u) *Department* means the United States Department of Labor (DOL).

(v) *Department of Energy* or *DOE* includes the predecessor agencies of the DOE, including the Manhattan Engineering District.

(w) *Department of Energy contractor employee* means any of the following:

(1) An individual who is or was in residence at a DOE facility as a researcher for one or more periods aggregating at least 24 months.

(2) An individual who is or was employed at a DOE facility by:

(i) An entity that contracted with the DOE to provide management and operating, management and integration, or environmental remediation at the facility; or

(ii) A contractor or subcontractor that provided services, including construction and maintenance, at the facility.

(x)(1) *Department of Energy facility* means, as determined by the Director of OWCP, any building, structure, or premise, including the grounds upon which such building, structure, or premise is located:

(i) In which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by E.O. 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and

(ii) With regard to which the DOE has or had:

(A) A proprietary interest; or

(B) Entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

(2) DOL has adopted the determinations of the Department of Energy regarding Department of Energy facilities that were contained in the list of facilities published in the FEDERAL REGISTER on August 23, 2004 (69 FR 51825). DOL will periodically update this list as it deems appropriate in its sole discretion by publishing a revised list of Department of Energy facilities in the FEDERAL REGISTER.

(y) *Disability* means, for purposes of determining entitlement to payment of Part B benefits under section 7384s(a)(1) of the Act, having been determined by OWCP to have or have had established chronic beryllium disease, cancer, or chronic silicosis.

(z) *Eligible surviving beneficiary* means any individual who is entitled under sections 7384s(e), 7384u(e), or 7385s–3(c) and (d) of the Act to receive a payment on behalf of a deceased covered Part B

employee or a deceased covered Part E employee.

(aa) *Employee* means either a current or former employee.

(bb) *Occupational illness* means, under Part B of the Act, a covered beryllium illness, cancer sustained in the performance of duty as defined in §30.210(a), specified cancer, chronic silicosis, or an illness for which DOJ has awarded compensation under section 5 of RECA.

(cc) *OWCP* means the Office of Workers' Compensation Programs, United States Department of Labor. One of the four divisions of OWCP is the Division of Energy Employees Occupational Illness Compensation.

(dd) *Physician* includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law. The term ''physician'' includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

(ee) *Qualified physician* means any physician who has not been excluded under the provisions of subpart H of this part. Except as otherwise provided by regulation, a qualified physician shall be deemed to be designated or approved by OWCP.

(ff) *Specified cancer* (as defined in section 4(b)(2) of RECA and in EEOICPA) means:

(1) Leukemia (other than chronic lymphocytic leukemia) provided that the onset of the disease was at least 2 years after first exposure;

(2) Lung cancer (other than in situ lung cancer that is discovered during or after a post-mortem exam);

(3) Bone cancer;

(4) Renal cancers; or

(5) The following diseases, provided onset was at least 5 years after first exposure:

(i) Multiple myeloma;

(ii) Lymphomas (other than Hodgkin's disease); and

(iii) Primary cancer of the:

(A) Thyroid;

(B) Male or female breast;

(C) Esophagus;

(D) Stomach;

(E) Pharynx;

(F) Small intestine;

(G) Pancreas;

(H) Bile ducts;

(I) Gall bladder;

(J) Salivary gland;

(K) Urinary bladder;

(L) Brain;

(M) Colon;

(N) Ovary; or

(O) Liver (except if cirrhosis or hepatitis B is indicated).

(6) The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature.

(gg) *Survivor* means:

(1) For claims under Part B of the Act, and subject to paragraph (gg)(3) of this section, a surviving spouse, child, parent, grandchild and grandparent of a deceased covered Part B employee.

(2) For claims under Part E of the Act, and subject to paragraph (gg)(3) of this section, a surviving spouse and child of a deceased covered Part E employee.

(3) Those individuals listed in paragraphs (gg)(1) and (gg)(2) of this section do not include any individuals not living as of the time OWCP makes a lump-sum payment or payments to an eligible surviving beneficiary or beneficiaries.

(hh) *Time of injury* means:

(1) In regard to a claim arising out of exposure to beryllium or silica, the last date on which a covered Part B employee was exposed to such substance in the performance of duty in accordance with sections 7384n(a) or 7384r(c) of the Act; or

(2) In regard to a claim arising out of exposure to radiation under Part B, the last date on which a covered Part B employee was exposed to radiation in the performance of duty in accordance with section 7384n(b) of the Act or, in the case of a member of the Special Exposure Cohort, the last date on which the member of the Special Exposure Cohort was employed at the Department of Energy facility or the atomic weapons employer facility at which the member was exposed to radiation; or

(3) In regard to a claim arising out of exposure to a toxic substance, the last date on which a covered Part E employee was employed at the Department of Energy facility or RECA section 5 facility, as appropriate, at which the exposure took place.

(ii) *Toxic substance* means any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature.

(jj) *Workday* means a single workshift whether or not it occurred on more than one calendar day.

INFORMATION IN PROGRAM RECORDS

§ 30.10 Are all OWCP records relating to claims filed under EEOICPA considered confidential?

All OWCP records relating to claims for benefits under EEOICPA are considered confidential and may not be released, inspected, copied or otherwise disclosed except as provided in the Freedom of Information Act and the Privacy Act of 1974.

§ 30.11 Who maintains custody and control of claim records?

All OWCP records relating to claims for benefits filed under the Act are covered by the Privacy Act system of records entitled DOL/ESA–49 (Office of Workers' Compensation Programs, Energy Employees Occupational Illness Compensation Program Act File). This system of records is maintained by and under the control of OWCP, and, as such, all records covered by DOL/ESA–49 are official records of OWCP. The protection, release, inspection and copying of records covered by DOL/ESA–49 shall be accomplished in accordance with the rules, guidelines and provisions of this part, as well as those contained in 29 CFR parts 70 and 71, and with the notice of the system of records and routine uses published in the FEDERAL REGISTER. All questions relating to access, disclosure, and/or amendment of claims records maintained by OWCP are to be resolved in accordance with this section.

§ 30.12 What process is used by a person who wants to obtain copies of or amend EEOICPA claim records?

(a) A claimant seeking copies of his or her official EEOICPA file should address a request to the District Director of the OWCP district office having custody of the file.

(b) Any request to amend a record covered by DOL/ESA–49 should be directed to the district office having custody of the official file.

(c) Any administrative appeal taken from a denial issued by OWCP under this section shall be filed with the Solicitor of Labor in accordance with 29 CFR 71.7 and 71.9.

RIGHTS AND PENALTIES

§ 30.15 May EEOICPA benefits be assigned, transferred or garnished?

(a) Pursuant to section 7385f(a) of the Act, no claim for EEOICPA benefits may be assigned or transferred.

(b) Provisions of the Social Security Act (42 U.S.C. 659) and regulations issued by the Office of Personnel Management at 5 CFR part 581 permit the garnishment of payments of EEOICPA monetary benefits to collect overdue alimony and child support. A request to garnish a payment for either of these purposes should be submitted to the district office that is handling the EEOICPA claim, and must be accompanied by a copy of the pertinent state agency or court order.

§ 30.16 What penalties may be imposed in connection with a claim under the Act?

(a) Other statutory provisions make it a crime to file a false or fraudulent claim or statement with the federal government in connection with a claim under the Act. Included among these provisions is 18 U.S.C. 1001. Enforcement of criminal provisions that may apply to claims under the Act is within the jurisdiction of the Department of Justice.

(b) In addition, administrative proceedings may be initiated under the Program Fraud Civil Remedies Act of 1986 (PFCRA), 31 U.S.C. 3801 *et seq.*, to impose civil penalties and assessments against persons or entities who make, submit or present, or cause to be made, submitted or presented, false, fictitious or fraudulent claims or written statements to OWCP in connection with a claim under EEOICPA. The Department's regulations implementing PFCRA are found at 29 CFR part 22.

§ 30.17 Is a beneficiary who defrauds the government in connection with a claim for EEOICPA benefits still entitled to those benefits?

When a beneficiary either pleads guilty to or is found guilty on either federal or state criminal charges of defrauding the federal or a state government in connection with a claim for benefits under the Act or any other federal or state workers' compensation law, the beneficiary forfeits (effective the date either the guilty plea is accepted or a verdict of guilty is returned after trial) any entitlement to any further benefits for any injury, illness or death covered by this part for which the time of injury was on or before the date of such guilty plea or verdict. Any subsequent change in or recurrence of the beneficiary's medical condition does not affect termination of entitlement under this section.

Subpart B—Filing Claims; Evidence and Burden of Proof; Special Procedures for Certain Cancer Claims

FILING CLAIMS FOR BENEFITS UNDER EEOICPA

§ 30.100 In general, how does an employee file an initial claim for benefits?

(a) To claim benefits under EEOICPA, an employee must file a claim in writing. Form EE–1 should be used for this purpose, but any written communication that requests benefits under EEOICPA will be considered a claim. It will, however, be necessary for an employee to submit a Form EE–1 for OWCP to fully develop the claim. Copies of Form EE–1 may be obtained from OWCP or on the Internet at *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*. The employee's claim must be filed with OWCP, but another person may do so on the employee's behalf.

(b) The employee may choose, at his or her own option, to file for benefits for only certain conditions that are potentially compensable under the Act (*e.g.*, the employee may not want to claim for an occupational illness or a covered illness for which a payment has been received that would necessitate an offset of EEOICPA benefits under the provisions of §30.505(b) of these regulations). The employee may withdraw his or her claim by so requesting in writing to OWCP at any time before OWCP determines his or her eligibility for benefits.

(c) Except as provided in paragraph (d) of this section, a claim is considered to be ''filed'' on the date that the employee mails his or her claim to OWCP, as determined by postmark, or on the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a claim under Part B of EEOICPA be considered to be ''filed'' earlier than July 31, 2001, nor will a claim under Part E of EEOICPA be considered to be ''filed'' earlier than October 30, 2000.

(1) The employee, or the person filing the claim on behalf of the employee, shall affirm that the information provided on the Form EE–1 is true, and must inform OWCP of any subsequent changes to that information.

(2) Except for a covered uranium employee filing a claim under Part B of the Act, the employee is responsible for submitting with his or her claim, or arranging for the submission of, medical evidence to OWCP that establishes that he or she sustained an occupational illness and/or a covered illness. This required medical evidence is described in §30.114 and does not refer to mere recitations of symptoms the employee experienced that the employee believes indicate that he or she sustained an occupational illness or a covered illness.

(d) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be ''filed'' on the date that the employee mailed his or her claim to DOE, as determined by postmark, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be ''filed'' earlier than October 30, 2000.

§ 30.101 In general, how is a survivor's claim filed?

(a) A survivor of an employee who sustained an occupational illness or a covered illness must file a claim for compensation in writing. Form EE–2 should be used for this purpose, but any written communication that requests survivor benefits under the Act will be considered a claim. It will, however, be necessary for a survivor to submit a Form EE–2 for OWCP to fully develop the claim. Copies of Form EE–2 may be obtained from OWCP or on the Internet at *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*. The survivor's claim must be filed with OWCP, but another person may do so on the survivor's behalf. Although only one survivor needs to file a claim under this section to initiate the development process, OWCP will distribute any monetary benefits payable on the claim among all eligible surviving beneficiaries who have filed claims with OWCP.

(b) A survivor may choose, at his or her own option, to file for benefits for only certain conditions that are potentially compensable under the Act (*e.g.*, the survivor may not want to claim for an occupational illness or a covered illness for which a payment has been received that would necessitate an offset of EEOICPA benefits under the provisions of § 30.505(b) of these regulations). The survivor may withdraw his or her claim by so requesting in writing to OWCP at any time before OWCP determines his or her eligibility for benefits.

(c) A survivor must be alive to receive any payment under EEOICPA; there is no vested right to such payment.

(d) Except as provided in paragraph (e) of this section, a survivor's claim is considered to be ''filed'' on the date that the survivor mails his or her claim to OWCP, as determined by postmark, or the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a survivor's claim under Part B of the Act be considered to be ''filed'' earlier than July 31, 2001, nor will a survivor's claim under Part E of the Act be considered to be ''filed'' earlier than October 30, 2000.

(1) The survivor, or the person filing the claim on behalf of the survivor, shall affirm that the information provided on the Form EE–2 is true, and must inform OWCP of any subsequent changes to that information.

(2) Except for the survivor of a covered uranium employee claiming under Part B of the Act, the survivor is responsible for submitting, or arranging for the submission of, evidence to OWCP that establishes that the employee upon whom the survivor's claim is based was eligible for such benefits, including medical evidence that establishes that the employee sustained an occupational illness or a covered illness. This required medical evidence is described in § 30.114 and does not refer to mere recitations by the survivor of symptoms the employee experienced that the survivor believes indicate that the employee sustained an occupational illness or a covered illness.

(e) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be ''filed'' on the date that the survivor mailed his or her claim to DOE, as determined by postmark, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be ''filed'' earlier than October 30, 2000.

(f) A spouse or a child of a deceased DOE contractor employee or RECA section 5 uranium worker, who is not a covered spouse or covered child under Part E, may submit a written request to OWCP for a determination of whether that deceased DOE contractor employee or RECA section 5 uranium worker contracted a covered illness under section 7385s–4(d) of EEOICPA.

(1) Any such request submitted pursuant to paragraph (f) of this section will not be considered a survivor's claim for benefits under Part E of the Act.

(2) As part of its consideration of any request submitted pursuant to paragraph (f) of this section, OWCP will apply the eligibility criteria in subpart

C of this part. However, the adjudicatory procedures contained in subpart D of this part will not apply to OWCP's consideration of such a request, and OWCP's response to the request will not constitute a final agency decision on entitlement to any benefits under EEOICPA.

§ 30.102 In general, how does an employee file a claim for additional impairment or wage-loss under Part E of EEOICPA?

(a) An employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the employee's minimum impairment rating attributable to the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

(b) An employee previously awarded wage-loss benefits by OWCP may be eligible for additional wage-loss benefits for periods of wage-loss that were not addressed in a prior claim only if the employee had not reached his or her Social Security retirement age at the time of the prior award. OWCP will adjudicate claims filed on a yearly basis in connection with each succeeding calendar year for which qualifying wage-loss under Part E is alleged, as well as claims that aggregate calendar years for which qualifying wage-loss is alleged.

(c) Employees should use Form EE–10 to claim for additional impairment or wage-loss benefits under Part E of EEOICPA.

(1) The employee, or the person filing the claim on behalf of the employee, shall affirm that the information provided on Form EE–10 is true, and must inform OWCP of any subsequent changes to that information.

(2) The employee is responsible for submitting with any claim filed under this section, or arranging for the submission of, factual and medical evidence establishing that he or she experienced another calendar year of qualifying wage-loss, and/or medical evidence establishing that he or she has an increased minimum impairment rating, as appropriate.

§ 30.103 How does a claimant make sure that OWCP has the evidence necessary to process the claim?

(a) Claims and certain required submissions should be made on forms prescribed by OWCP. Persons submitting forms shall not modify these forms or use substitute forms.

Form No.	Title
(1) EE–1 ..	Claim for Benefits Under the Energy Employees Occupational Illness Compensation Program Act.
(2) EE–2 ..	Claim for Survivor Benefits Under the Energy Employees Occupational Illness Compensation Program Act.
(3) EE–3 ..	Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act.
(4) EE–4 ..	Employment History Affidavit for a Claim Under the Energy Employees Occupational Illness Compensation Program Act.

(b) Copies of the forms listed in this section are available for public inspection at the Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from OWCP district offices and on the Internet at *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*.

VERIFICATION OF ALLEGED EMPLOYMENT

§ 30.105 What must DOE do after an employee or survivor files a claim?

(a) After it receives a claim for benefits described in §§ 30.100 or 30.101, OWCP may request that DOE verify the employment history provided by the claimant. Upon receipt of such a request, DOE will complete Form EE–5 as soon as possible and transmit the completed form to OWCP. On this form, DOE will certify either that it concurs with the employment history provided by the claimant, that it disagrees with such history, or that it can neither concur nor disagree after making a reasonable search of its records and also making a reasonable effort to

locate pertinent records not already in its possession.

(b) Claims for additional impairment or wage-loss benefits under Part E of the Act described in § 30.102 will not require any verification of employment by DOE, since OWCP will have made any required findings on this particular issue when it adjudicated the employee's initial claim for benefits.

§ 30.106 Can OWCP request employment verification from other sources?

(a) For most claims filed under EEOICPA, DOE has access to sufficient factual information to enable it to fulfill its obligations described in § 30.105(a). However, in instances where it lacks such information, DOE may arrange for other entities to provide OWCP with the information necessary to verify an employment history submitted as part of a claim. These other entities may consist of either current or former DOE contractors and subcontractors, atomic weapons employers, beryllium vendors, or other entities with access to relevant employment information.

(b) On its own initiative, OWCP may also arrange for entities other than DOE to perform the employment verification duties described in § 30.105(a).

Evidence and Burden of Proof

§ 30.110 Who is entitled to compensation under the Act?

(a) Under Part B of EEOICPA, compensation is payable to the following covered Part B employees, or their survivors:

(1) A ''covered beryllium employee'' (as described in § 30.205(a)) with a covered beryllium illness (as defined in § 30.5(o)) who was exposed to beryllium in the performance of duty (in accordance with § 30.206).

(2) A ''covered Part B employee with cancer'' (as described in § 30.210(a)).

(3) A ''covered Part B employee with chronic silicosis'' (as described in § 30.220).

(4) A ''covered uranium employee'' (as defined in § 30.5(s)).

(b) Under Part E of EEOICPA, compensation is payable to a ''covered Part E employee'' (as defined in § 30.5(p)), or his or her survivors.

(c) Any claim that does not meet all of the criteria for at least one of these categories, as set forth in the regulations in this part, must be denied.

(d) All claims for benefits under the Act must comply with the claims procedures and requirements set forth in subpart B of this part before any payment can be made from the Fund.

§ 30.111 What is the claimant's responsibility with respect to burden of proof, production of documents, presumptions, and affidavits?

(a) Except where otherwise provided in the Act and these regulations, the claimant bears the burden of proving by a preponderance of the evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category set forth in § 30.110. Proof by a preponderance of the evidence means that it is more likely than not that the proposition to be proved is true. Subject to the exceptions expressly provided in the Act and the regulations in this part, the claimant also bears the burden of providing to OWCP all written medical documentation, contemporaneous records, or other records and documents necessary to establish any and all criteria for benefits set forth in these regulations.

(b) In the event that the claim lacks required information or supporting documentation, OWCP will notify the claimant of the deficiencies and provide him or her an opportunity for correction of the deficiencies.

(c) Written affidavits or declarations, subject to penalty for perjury, by the employee, survivor or any other person, will be accepted as evidence of employment history and survivor relationship for purposes of establishing eligibility and may be relied on in determining whether a claim meets the requirements of the Act for benefits if, and only if, such person attests that due diligence was used to obtain records in support of the claim, but that no records exist.

(d) A claimant will not be entitled to any presumption otherwise provided for in these regulations if substantial

evidence exists that rebuts the existence of the fact that is the subject of the presumption. Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. When such evidence exists, the claimant shall be notified and afforded the opportunity to submit additional written medical documentation or records.

§ 30.112 What kind of evidence is needed to establish covered employment and how will that evidence be evaluated?

(a) Evidence of covered employment may include: employment records; pay stubs; tax returns; Social Security records; and written affidavits or declarations, subject to penalty of perjury, by the employee, survivor or any other person. However, no one document is required to establish covered employment and a claimant is not required to submit all of the evidence listed above. A claimant may submit other evidence not listed above to establish covered employment. To be acceptable as evidence, all documents and records must be legible. OWCP will accept photocopies, certified copies, and original documents and records.

(b) Pursuant to §§ 30.105 and/or 30.106, DOE or another entity verifying alleged employment shall certify that it concurs with the employment information provided by the claimant, that it disagrees with the information provided by the claimant, or, after a reasonable search of its records and a reasonable effort to locate pertinent records not already in its possession, it can neither concur nor disagree with the information provided by the claimant.

(1) If DOE or another entity certifies that it concurs with the employment information provided by the claimant, then the criterion for covered employment will be established.

(2) If DOE or another entity certifies that it disagrees with the information provided by the claimant or that after a reasonable search of its records and a reasonable effort to locate pertinent records not already in its possession it can neither concur nor disagree with the information provided by the claimant, OWCP will evaluate the evidence submitted by the claimant to determine whether the claimant has established covered employment by a preponderance of the evidence. OWCP may request additional evidence from the claimant to demonstrate that the claimant has met the criterion for covered employment. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(3) If the only evidence of covered employment is a self-serving affidavit and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP may reject the claim based upon a lack of evidence of covered employment.

§ 30.113 What are the requirements for written medical documentation, contemporaneous records, and other records or documents?

(a) All written medical documentation, contemporaneous records, and other records or documents submitted by an employee or his or her survivor to prove any criteria provided for in these regulations must be legible. OWCP will accept photocopies, certified copies, and original documents and records.

(b) To establish eligibility, the employee or his or her survivor may be required to provide, where appropriate, additional contemporaneous records to the extent they exist or an authorization to release additional contemporaneous records or a statement by the custodian(s) of the record(s) certifying that the requested record(s) no longer exist. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(c) If a claimant submits a certified statement, by a person with knowledge of the facts, that the medical records containing a diagnosis and date of diagnosis of a covered medical condition no longer exist, then OWCP may consider other evidence to establish a diagnosis and date of diagnosis of a covered medical condition. However, if the certified statement is a self-serving document, OWCP may reject the claim based upon a lack of evidence of a covered medical condition.

§ 30.114 What kind of evidence is needed to establish a compensable medical condition and how will that evidence be evaluated?

(a) Evidence of a compensable medical condition may include: a physician's report, laboratory reports, hospital records, death certificates, x-rays, magnetic resonance images or reports, computer axial tomography or other imaging reports, lymphocyte proliferation testings, beryllium patch tests, pulmonary function or exercise testing results, pathology reports including biopsy results and other medical records. A claimant is not required to submit all of the evidence listed in this paragraph. A claimant may submit other evidence that is not listed in this paragraph to establish a compensable medical condition. Nothing in this section shall be construed to limit OWCP's ability to require additional documentation.

(b) The medical evidence submitted will be used to establish the diagnosis and the date of diagnosis of the compensable medical condition.

(1) For covered beryllium illnesses, additional medical evidence, as set forth in § 30.207, is required to establish a beryllium illness.

(2) For chronic silicosis, additional medical evidence, as set forth in § 30.222, is required to establish chronic silicosis.

(3) For consequential injuries, illnesses, impairments or diseases, the claimant must also submit a physician's fully rationalized medical report showing a causal relationship between the resulting injury, illness, impairment or disease and the compensable medical condition.

(c) OWCP will evaluate the medical evidence in accordance with recognized and accepted diagnostic criteria used by physicians to determine whether the claimant has established the medical condition for which compensation is sought in accordance with the requirements of the Act.

Special Procedures for Certain Radiogenic Cancer Claims

§ 30.115 For those radiogenic cancer claims that do not seek benefits under Part B of the Act pursuant to the Special Exposure Cohort provisions, what will OWCP do once it determines that an employee contracted cancer?

(a) Other than claims for a non-radiogenic cancer listed by HHS at 42 CFR 81.30, or claims seeking benefits under Part E of the Act that have previously been accepted under section 7384u of the Act, or claims previously accepted under Part B pursuant to the Special Exposure Cohort provisions, OWCP will forward the claim package (including, but not limited to, Forms EE–1, EE–2, EE–3, EE–4 and EE–5, as appropriate) to HHS for dose reconstruction. At that point in time, development of the claim by OWCP may be suspended.

(1) This package will include OWCP's initial findings in regard to the diagnosis and date of diagnosis of the employee, as well as any employment history compiled by OWCP (including information such as dates and locations worked, and job titles). The package, however, will not constitute either a recommended or final decision by OWCP on the claim.

(2) HHS will then reconstruct the radiation dose of the employee, after such further development of the employment history as it may deem necessary, and provide OWCP, DOE and the claimant with the final dose reconstruction report. The final dose reconstruction record will be delivered to OWCP with the final dose reconstruction report and to the claimant upon request.

(b) Following its receipt of the reconstructed dose from HHS, OWCP will resume its adjudication of the cancer claim and consider whether the claimant has met the eligibility criteria set forth in subpart C of this part. However, during the period before it receives a reconstructed dose from HHS, OWCP may continue to develop other aspects of a claim, to the extent that it deems such development to be appropriate.

Subpart C—Eligibility Criteria

GENERAL PROVISIONS

§ 30.200 What is the scope of this subpart?

The regulations in this subpart describe the criteria for eligibility for benefits for claims under Part B of EEOICPA relating to covered beryllium illness under sections 7384l, 7384n, 7384s and 7384t of the Act; for cancer under sections 7384l, 7384n, 7384q and 7384t of the Act; for chronic silicosis under sections 7384l, 7384r, 7384s and 7384t of the Act; and for claims relating to covered uranium employees under sections 7384t and 7384u of the Act. These regulations also describe the criteria for eligibility for benefits for claims under Part E of EEOICPA relating to covered illnesses under sections 7385s–4 and 7385s–5 of the Act. This subpart describes the type and extent of evidence that will be necessary to establish the criteria for eligibility for compensation for these illnesses.

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO COVERED BERYLLIUM ILLNESS UNDER PART B OF EEOICPA

§ 30.205 What are the criteria for eligibility for benefits relating to beryllium illnesses covered under Part B of EEOICPA?

To establish eligibility for benefits under this section, the claimant must establish the criteria set forth in both paragraphs (a) and (b) of this section:

(a) The employee is a covered beryllium employee only if the criteria in paragraphs (a)(1) and (a)(3) of this section, or (a)(2) and (a)(3) of this section, are established:

(1) The employee is a ''current or former employee as defined in 5 U.S.C. 8101(1)'' (see § 30.5(t) of this part) who may have been exposed to beryllium at a DOE facility or at a facility owned, operated, or occupied by a beryllium vendor; or

(2) The employee is a current or former civilian employee of:

(i) Any entity that contracted with the DOE to provide management and operation, management and integration, or environmental remediation of a DOE facility; or

(ii) Any contractor or subcontractor that provided services, including construction and maintenance, at such a facility; or

(iii) A beryllium vendor, or of a contractor or subcontractor of a beryllium vendor, during a period when the vendor was engaged in activities related to the production or processing of beryllium for sale to, or use by, the DOE, including periods during which environmental remediation of a vendor's facility was undertaken pursuant to a contract between the vendor and DOE; and

(3) The civilian employee was exposed to beryllium in the performance of duty by establishing that he or she was, during a period when beryllium dust, particles, or vapor may have been present at such a facility:

(i) Employed at a DOE facility (as defined in § 30.5(x) of this part); or

(ii) Present at a DOE facility, or at a facility owned, operated, or occupied by a beryllium vendor, because of his or her employment by the United States, a beryllium vendor, a contractor or subcontractor of a beryllium vendor, or a contractor or subcontractor of the DOE. Under this paragraph, exposure to beryllium in the performance of duty can be established whether or not the beryllium that may have been present at such facility was produced or processed for sale to, or use by, DOE.

(b) The employee has one of the following:

(1) Beryllium sensitivity as established by an abnormal beryllium LPT performed on either blood or lung lavage cells.

(2) Established chronic beryllium disease.

(3) Any injury, illness, impairment, or disability sustained as a consequence of the conditions specified in paragraphs (b)(1) and (2) of this section.

§ 30.206 How does a claimant prove that the employee was a "covered beryllium employee" exposed to beryllium dust, particles or vapor in the performance of duty?

(a) Proof of employment at or physical presence at a DOE facility, or a facility owned, operated, or occupied by a beryllium vendor, because of employment by the United States, a beryllium

vendor, or a contractor or subcontractor of a beryllium vendor during a period when beryllium dust, particles, or vapor may have been present at such a facility, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was employed or present at a covered facility and the time period of such employment or presence.

(b) If the evidence shows that exposure occurred while the employee was employed or present at a facility during a time frame that is outside the relevant time frame indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether the evidence of record supports enlarging the relevant time frame for that facility.

(c) If the evidence shows that exposure occurred while the employee was employed or present at a facility that would have to be designated by DOE as a beryllium vendor under section 7384m of the Act to be a covered facility, and that the facility has not been so designated, OWCP will deny the claim on the ground that the facility is not a covered facility.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created by any vendor, processor, or producer of beryllium or related products designated as a beryllium vendor by the DOE in accordance with section 7384m of the Act.

(3) Records or documents created as a by product of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

§ 30.207 How does a claimant prove a diagnosis of a beryllium disease covered under Part B?

(a) Written medical documentation is required in all cases to prove that the employee developed a covered beryllium illness. Proof that the employee developed a covered beryllium illness must be made by using the procedures outlined in paragraphs (b), (c), or (d) of this section.

(b) Beryllium sensitivity or sensitization is established with an abnormal LPT performed on either blood or lung lavage cells.

(c) Chronic beryllium disease is established in the following manner:

(1) For diagnoses on or after January 1, 1993, beryllium sensitivity (as established in accordance with paragraph (b) of this section), together with lung pathology consistent with chronic beryllium disease, including the following:

(i) A lung biopsy showing granulomas or a lymphocytic process consistent with chronic beryllium disease;

(ii) A computerized axial tomography scan showing changes consistent with chronic beryllium disease; or

(iii) Pulmonary function or exercise testing showing pulmonary deficits consistent with chronic beryllium disease.

(2) For diagnoses before January 1, 1993, the presence of the following:

(i) Occupational or environmental history, or epidemiologic evidence of beryllium exposure; and

(ii) Any three of the following criteria:

(A) Characteristic chest radiographic (or computed tomography (CT)) abnormalities.

(B) Restrictive or obstructive lung physiology testing or diffusing lung capacity defect.

(C) Lung pathology consistent with chronic beryllium disease.

(D) Clinical course consistent with a chronic respiratory disorder.

(E) Immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred).

(d) An injury, illness, impairment or disability sustained as a consequence of beryllium sensitivity or established chronic beryllium disease must be established with a fully rationalized medical report by a physician that

shows the relationship between the injury, illness, impairment or disability and the beryllium sensitivity or established chronic beryllium disease. Neither the fact that the injury, illness, impairment or disability manifests itself after a diagnosis of beryllium sensitivity or established chronic beryllium disease, nor the belief of the claimant that the injury, illness, impairment or disability was caused by the beryllium sensitivity or established chronic beryllium disease, is sufficient in itself to prove a causal relationship.

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO RADIOGENIC CANCER UNDER PARTS B AND E OF EEOICPA

§ 30.210 What are the criteria for eligibility for benefits relating to radiogenic cancer?

(a) To establish eligibility for benefits for radiogenic cancer under Part B of EEOICPA, an employee or his or her survivor must show that:

(1) The employee has been diagnosed with one of the forms of cancer specified in §30.5(ff) of this part; and

(i) Is a member of the Special Exposure Cohort (as described in §30.214(a) of this subpart) who, as a civilian DOE employee or civilian DOE contractor employee, contracted the specified cancer after beginning employment at a DOE facility; or

(ii) Is a member of the Special Exposure Cohort (as described in §30.214(a) of this subpart) who, as a civilian atomic weapons employee, contracted the specified cancer after beginning employment at an atomic weapons employer facility (as defined in §30.5(e)); or

(2) The employee has been diagnosed with cancer; and

(i)(A) Is/was a civilian DOE employee who contracted that cancer after beginning employment at a DOE facility; or

(B) Is/was a civilian DOE contractor employee who contracted that cancer after beginning employment at a DOE facility; or

(C) Is/was a civilian atomic weapons employee who contracted that cancer after beginning employment at an atomic weapons employer facility; and

(ii) The cancer was at least as likely as not related to the employment at the DOE facility or atomic weapons employer facility; or

(3) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted cancer.

(b)(1) To establish eligibility for benefits for radiogenic cancer under Part E of EEOICPA, an employee or his or her survivor must show that:

(i) The employee has been diagnosed with cancer; and

(A) Is/was a civilian DOE contractor employee or a civilian RECA section 5 uranium worker who contracted that cancer after beginning employment at a DOE facility or a RECA section 5 facility; and

(B) The cancer was at least as likely as not related to exposure to a toxic substance of a radioactive nature at a DOE facility or a RECA section 5 facility; and

(C) It is at least as likely as not that the exposure to such toxic substance(s) was related to employment at a DOE facility or a RECA section 5 facility; or

(ii) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted cancer.

(2) Eligibility for benefits for radiogenic cancer under Part E in a claim that has previously been accepted under Part B pursuant to the Special Exposure Cohort provisions is described in §30.230(a) of these regulations.

§ 30.211 How does a claimant establish that the employee has or had contracted cancer?

A claimant establishes that the employee has or had contracted a specified cancer (as defined in §30.5(ff)) or other cancer with medical evidence that sets forth an explicit diagnosis of cancer and the date on which that diagnosis was first made.

§ 30.212 How does a claimant establish that the employee contracted cancer after beginning employment at a DOE facility, an atomic weapons employer facility or a RECA section 5 facility?

(a) Proof of employment by the DOE or a DOE contractor at a DOE facility,

or by an atomic weapons employer at an atomic weapons employer facility, or at a RECA section 5 facility, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment.

(b)(1) Except as provided in paragraph (b)(2) of this section, if the evidence shows that exposure occurred while the employee was employed at a facility during a time frame that is outside the relevant period indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether the evidence of record supports enlarging the relevant period for that facility.

(2) OWCP may choose not to request that DOE provide additional information on an atomic weapons employer facility that NIOSH reported had a potential for significant residual radiation contamination in its report dated October 2003 and titled ''Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities,'' or any update to that report, if the evidence referred to in paragraph (a) of this section establishes that the employee was employed at that facility during a period when NIOSH reported that it had a potential for significant residual radiation contamination.

(c) If the evidence shows that exposure occurred while the employee was employed by an employer that would have to be designated by DOE as an atomic weapons employer under section 7384l(4) of the Act to be a covered employer, and that the employer has not been so designated, OWCP will deny the claim on the ground that the employer is not a covered atomic weapons employer.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

§ 30.213 How does a claimant establish that the radiogenic cancer was at least as likely as not related to employment at the DOE facility, the atomic weapons employer facility, or the RECA section 5 facility?

(a) HHS, with the advice of the Advisory Board on Radiation and Worker Health, has issued regulatory guidelines at 42 CFR part 81 that OWCP uses to determine whether radiogenic cancers claimed under Parts B and E were at least as likely as not related to employment at a DOE facility, an atomic weapons employer facility, or a RECA section 5 facility, as appropriate. Persons should consult HHS's regulations for information regarding the factual evidence that will be considered by OWCP, in addition to the employee's radiation dose reconstruction that will be provided to OWCP by HHS, in making this particular factual determination.

(b) HHS's regulations satisfy the legal requirements in section 7384n(c) of the Act, which also sets out OWCP's obligation to use them in its adjudication of claims for radiogenic cancer filed under Part B of the Act, and provide the factual basis for OWCP to determine if the ''probability of causation'' (PoC) that an employee's cancer was sustained in the performance of duty is 50% or greater (*i.e.*, it is ''at least as likely as not'' causally related to employment), as required under section 7384n(b).

(c) OWCP also uses HHS's regulations when it makes the determination required by section 7385s–4(c)(1)(A) of the Act, since those regulations provide the factual basis for OWCP to determine if ''it is at least as likely as not'' that exposure to radiation at a DOE facility or RECA section 5 facility, as appropriate, was a significant factor in aggravating, contributing to, or causing the employee's radiogenic cancer claimed under Part E. For cancer claims under Part E, if the PoC is less

than 50% and the claimant alleges that the employee was exposed to additional toxic substances, OWCP will determine if the claim is otherwise compensable pursuant to §30.230(d) of this part.

§ 30.214 How does a claimant establish that the employee is a member of the Special Exposure Cohort?

(a) For purposes of establishing eligibility as a member of the Special Exposure Cohort (SEC) under §30.210(a)(1), the employee must have been a DOE employee, a DOE contractor employee, or an atomic weapons employee who meets any of the following requirements:

(1) The employee was so employed for a number of workdays aggregating at least 250 workdays before February 1, 1992, at a gaseous diffusion plant located in Paducah, Kentucky; Portsmouth, Ohio; or Oak Ridge, Tennessee; and during such employment:

(i) Was monitored through the use of dosimetry badges for exposure at the plant of the external parts of the employee's body to radiation; or

(ii) Worked in a job that had exposures comparable to a job that is or was monitored through the use of dosimetry badges.

(2) The employee was so employed before January 1, 1974, by DOE or a DOE contractor or subcontractor on Amchitka Island, Alaska, and was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests.

(3) The employee is a member of a group or class of employees subsequently designated as additional members of the SEC by HHS.

(b) For purposes of satisfying the 250 workday requirement of paragraph (a)(1) of this section, the claimant may aggregate the days of service at more than one gaseous diffusion plant.

(c) Proof of employment by the DOE or a DOE contractor, or an atomic weapons employer, for the requisite time periods set forth in paragraph (a) of this section, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment. If the evidence shows that exposure occurred while the employee was employed by an employer that would have to be designated by DOE as an atomic weapons employer under section 7384l(4) of the Act to be a covered employer, and that the employer has not been so designated, OWCP will deny the claim on the ground that the employer is not a covered atomic weapons employer.

(d) Records from the following sources may be considered as evidence for purposes of establishing employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

§ 30.215 How does a claimant establish that the employee has sustained an injury, illness, impairment or disease as a consequence of a diagnosed cancer?

An injury, illness, impairment or disease sustained as a consequence of a diagnosed cancer covered by the provisions of §30.210 must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the cancer. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a cancer, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the cancer, is sufficient in itself to prove a causal relationship.

ELIGIBILITY CRITERIA FOR CLAIMS RELATING TO CHRONIC SILICOSIS UNDER PART B OF EEOICPA

§ 30.220 What are the criteria for eligibility for benefits relating to chronic silicosis?

To establish eligibility for benefits for chronic silicosis under Part B of

EEOICPA, an employee or his or her survivor must show that:

(a) The employee is a civilian DOE employee, or a civilian DOE contractor employee, who was present for a number of workdays aggregating at least 250 workdays during the mining of tunnels at a DOE facility (as defined in § 30.5(x)) located in Nevada or Alaska for tests or experiments related to an atomic weapon, and has been diagnosed with chronic silicosis (as defined in § 30.5(j)); or

(b) The employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the accepted chronic silicosis.

§ 30.221 How does a claimant prove exposure to silica in the performance of duty?

(a) Proof of the employee's employment and presence for the requisite days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and present at these sites and the time period(s) of such employment and presence.

(b) If the evidence shows that exposure occurred while the employee was employed and present at a facility during a time frame that is outside the relevant time frame indicated for that facility, OWCP may request that DOE provide additional information on the facility. OWCP will determine whether the evidence of record supports enlarging the relevant time frame for that facility.

(c) Records from the following sources may be considered as evidence for purposes of establishing proof of employment or presence at a covered facility:

(1) Records or documents created by any federal government agency (including verified information submitted for security clearance), any tribal government, or any state, county, city or local government office, agency, department, board or other entity, or other public agency or office.

(2) Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to the DOE.

(d) For purposes of satisfying the 250 workday requirement of § 30.220(a), the claimant may aggregate the days of service at more than one qualifying site.

§ 30.222 How does a claimant establish that the employee has been diagnosed with chronic silicosis or has sustained a consequential injury, illness, impairment or disease?

(a) A written diagnosis of the employee's chronic silicosis (as defined in § 30.5(j)) shall be made by a medical doctor and accompanied by one of the following:

(1) A chest radiograph, interpreted by an individual certified by NIOSH as a B reader, classifying the existence of pneumoconioses of category 1/0 or higher; or

(2) Results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(3) Lung biopsy findings consistent with silicosis.

(b) An injury, illness, impairment or disease sustained as a consequence of accepted chronic silicosis covered by the provisions of § 30.220(a) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the accepted chronic silicosis. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of accepted chronic silicosis, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the accepted chronic silicosis, is sufficient in itself to prove a causal relationship.

Eligibility Criteria for Certain Uranium Employees Under Part B of EEOICPA

§ 30.225 What are the criteria for eligibility for benefits under Part B of EEOICPA for certain uranium employees?

In order to be eligible for benefits under this section, the claimant must establish the criteria set forth in either

paragraph (a) or paragraph (b) of this section:

(a) The Attorney General has determined that the claimant is a covered uranium employee who is entitled to payment of $100,000 as compensation due under section 5 of RECA for a claim made under that statute (there is, however, no requirement that the claimant or surviving eligible beneficiary has actually received payment pursuant to RECA). If a deceased employee's survivor(s) has been determined to be entitled to such an award, his or her survivor(s), if any, will only be entitled to EEOICPA compensation in accordance with section 7384u(e) of the Act.

(b) The covered uranium employee has been diagnosed with an injury, illness, impairment or disease that arose as a consequence of the medical condition for which he or she was determined to be entitled to payment of $100,000 as compensation due under section 5 of RECA.

§ 30.226 How does a claimant establish that a covered uranium employee has sustained a consequential injury, illness, impairment or disease?

An injury, illness, impairment or disease sustained as a consequence of a medical condition covered by the provisions of § 30.225(a) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the accepted medical condition. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a medical condition covered by the provisions of § 30.225(a), nor the belief of the claimant that the injury, illness, impairment or disease was caused by such a condition, is sufficient in itself to prove a causal relationship.

ELIGIBILITY CRITERIA FOR OTHER CLAIMS UNDER PART E OF EEOICPA

§ 30.230 What are the criteria necessary to establish that an employee contracted a covered illness under Part E of EEOICPA?

To establish that an employee contracted a covered illness under Part E of the Act, the employee, or his or her survivor, must show one of the following:

(a) That OWCP has determined under Part B of EEOICPA that the employee is a Department of Energy contractor employee as defined in § 30.5(w), and that he or she has been awarded compensation under that Part of the Act for an occupational illness;

(b) That the Attorney General has determined that the employee is entitled to payment of $100,000 as compensation due under section 5 of RECA for a claim made under that statute (however, if a deceased employee's survivor has been determined to be entitled to such an award, his or her survivor(s), if any, will only be entitled to benefits under Part E of EEOICPA in accordance with section 7385s–3 of the Act);

(c) That the Secretary of Energy has accepted a positive determination of a Physicians Panel that the employee sustained an illness or died due to exposure to a toxic substance at a DOE facility under former section 7385o of EEOICPA, or that the Secretary of Energy has found significant evidence contrary to a negative determination of a Physicians Panel; or

(d)(1) That the employee is a civilian Department of Energy contractor employee as defined in § 30.5(w), or a civilian who was employed in a uranium mine or mill located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon or Texas at any time during the period from January 1, 1942 through December 31, 1971, or was employed in the transport of uranium ore or vanadium-uranium ore from such a mine or mill during that same period, and that he or she:

(i) Has been diagnosed with an illness; and

(ii) That it is at least as likely as not that exposure to a toxic substance at a Department of Energy facility or at a RECA section 5 facility, as appropriate, was a significant factor in aggravating, contributing to, or causing the illness; and

(iii) That it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility or a RECA section 5 facility, as appropriate.

(2) In making the determination under paragraph (d)(1)(ii) of this section, OWCP will consider:

(i) The nature, frequency and duration of exposure of the covered employee to the substance alleged to be toxic;

(ii) Evidence of the carcinogenic or pathogenic properties of the alleged toxic substance to which the employee was exposed;

(iii) An opinion of a qualified physician with expertise in treating, diagnosing or researching the illness claimed to be caused or aggravated by the alleged exposure; and

(iv) Any other evidence that OWCP determines to have demonstrated relevance to the relation between a particular toxic substance and the claimed illness.

§ 30.231 How does a claimant prove employment-related exposure to a toxic substance at a DOE facility or a RECA section 5 facility?

To establish employment-related exposure to a toxic substance at a Department of Energy facility or RECA section 5 facility as required by § 30.230(d), an employee, or his or her survivor(s), must prove that the employee was employed at such facility and that he or she was exposed to a toxic substance in the course of that employment.

(a) Proof of employment may be established by any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment.

(b) Proof of exposure to a toxic substance may be established by the submission of any appropriate document or information that is evidence that such substance was present at the facility in which the employee was employed and that the employee came into contact with such substance. OWCP site exposure matrices may be used to provide probative factual evidence that a particular substance was present at either a DOE facility or a RECA section 5 facility.

§ 30.232 How does a claimant establish that the employee has been diagnosed with a covered illness, or sustained an injury, illness, impairment or disease as a consequence of a covered illness?

(a) To establish that the employee has been diagnosed with a covered illness as required by § 30.230(d), the employee, or his or her survivor(s), must provide the following:

(1) The name and address of any licensed physician who is the source of a diagnosis based upon documented medical information that the employee has or had an illness and that the illness may have resulted from exposure to a toxic substance while the employee was employed at a DOE facility or a RECA section 5 facility, as appropriate, and, to the extent practicable, a copy of the diagnosis and a summary of the information upon which the diagnosis is based; and

(2) A signed medical release, authorizing the release of any diagnosis, medical opinion and medical records documenting the diagnosis or opinion that the employee has or had an illness and that the illness may have resulted from exposure to a toxic substance while the employee was employed at a DOE facility or RECA section 5 facility, as appropriate; and

(3) To the extent practicable and appropriate, an occupational history obtained by a physician, an occupational health professional, or a DOE-sponsored Former Worker Program (if such an occupational history is not reasonably available or is inadequate, and such history is deemed by OWCP to be needed for the fair adjudication of the claim, then OWCP may assist the claimant in developing this history); and

(4) Any other information or materials deemed by OWCP to be necessary to provide reasonable evidence that the employee has or had an illness that may have arisen from exposure to a toxic substance while employed at a DOE facility or RECA section 5 facility, as appropriate.

(b) The employee, or his or her survivor(s), may also submit to OWCP other evidence not described in paragraph (a) of this section showing that the employee has or had an illness that

resulted from an exposure to a toxic substance during the course of employment at either a DOE facility or a RECA section 5 facility, as appropriate.

(c) An injury, illness, impairment or disease sustained as a consequence of a covered illness (as defined in §30.5(r)) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the covered illness. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a covered illness, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the covered illness, is sufficient in itself to prove a causal relationship.

Subpart D—Adjudicatory Process

§30.300 What process will OWCP use to decide claims for entitlement and to provide for administrative review of those decisions?

OWCP district offices will issue recommended decisions with respect to claims for entitlement under Part B and/or Part E of EEOICPA that are filed pursuant to the regulations set forth in subpart B of this part. In circumstances where a claim is made for more than one benefit available under Part B and/or Part E of the Act, OWCP may issue a recommended decision on only part of that particular claim in order to adjudicate that portion of the claim as quickly as possible. Should this occur, OWCP will issue one or more recommended decisions on the deferred portions of the claim when the adjudication of those portions is completed. All recommended decisions granting and/or denying benefits under Part B and/or Part E of the Act will be forwarded to the Final Adjudication Branch (FAB). Claimants will be given an opportunity to object to all or part of the recommended decision before the FAB. The FAB will consider objections filed by a claimant and conduct a hearing, if requested to do so by the claimant, before issuing a final decision on the claim for entitlement.

§30.301 May subpoenas be issued for witnesses and documents in connection with a claim under Part B of EEOICPA?

(a) In connection with the adjudication of a claim under Part B of EEOICPA, an OWCP district office and/or a FAB reviewer may, at their own initiative, issue subpoenas for the attendance and testimony of witnesses, and for the production of books, electronic records, correspondence, papers or other relevant documents. Subpoenas will only be issued for documents if they are relevant and cannot be obtained by other means, and for witnesses only where oral testimony is the best way to ascertain the facts.

(b) A claimant may also request a subpoena in connection with his or her claim under Part B of the Act, but such request may only be made to a FAB reviewer. No subpoenas will be issued at the request of the claimant under any other portion of the claims process. The decision to grant or deny such request is within the discretion of the FAB reviewer. To request a subpoena under this section, the requestor must:

(1) Submit the request in writing and send it to the FAB reviewer as early as possible, but no later than 30 days (as evidenced by postmark, electronic marker or other objective date mark) after the date of the original hearing request;

(2) Explain why the testimony or evidence is directly relevant and material to the issues in the case; and

(3) Establish that a subpoena is the best method or opportunity to obtain such evidence because there are no other means by which the documents or testimony could have been obtained.

(c) No subpoena will be issued for attendance of employees or contractors of OWCP or NIOSH acting in their official capacities as decision-makers or policy administrators. For hearings taking the form of a review of the written record, no subpoena for the appearance of witnesses will be considered.

(d) The FAB reviewer will issue the subpoena under his or her own name. It may be served in person or by certified mail, return receipt requested, addressed to the person to be served at his or her last known principal place of business or residence. A decision to

deny a subpoena requested by a claimant can only be challenged as part of a request for reconsideration of any adverse decision of the FAB which results from the hearing.

§ 30.302 Who pays the costs associated with subpoenas?

(a) Witnesses who are not employees or former employees of the federal government shall be paid the same fees and mileage as paid for like services in the District Court of the United States where the subpoena is returnable, except that expert witnesses shall be paid a fee not to exceed the local customary fee for such services.

(b) Where OWCP asked that the witness submit evidence into the case record or asked that the witness attend, OWCP shall pay the fees and mileage. Where the claimant asked for the subpoena, and where the witness submitted evidence into the record at the request of the claimant, the claimant shall pay the fees and mileage.

§ 30.303 What information may OWCP request in connection with a claim under Part E of EEOICPA?

At any time during the course of development of a claim for benefits under Part E, OWCP may determine that it needs relevant information to adjudicate the claim. When this occurs, and at the request of OWCP, DOE and/or any contractor who employed a Department of Energy contractor employee must provide to OWCP information or documents in response to the request in connection with a claim under Part E of EEOICPA.

(a) The party to whom the request is made must respond to OWCP within 90 days of the request with either:

(1) The requested information or documents; or

(2) A sworn statement that a good faith search for the requested information or documents was conducted, and that the information or documents could not be located.

(b) DOE and/or the DOE contractor who employed a Department of Energy contractor employee must query third parties under its control to acquire the requested information or documents.

(c) In providing the requested information or documents, DOE and/or the DOE contractor who employed a DOE contractor employee must preserve the current organization of the requested information or documents, and must provide such description and indexing of the requested information or documents as OWCP considers appropriate to facilitate their use by OWCP.

(d) Information or document requests may include, but are not limited to, requests for records, files and other data, whether paper, electronic, imaged or otherwise, developed, acquired or maintained by DOE or the DOE contractor who employed a DOE contractor employee. Such information or documents may include records, files and data on facility industrial hygiene, employment of individuals or groups, exposure and medical records, and claims applications.

Recommended Decisions on Claims

§ 30.305 How does OWCP determine entitlement to EEOICPA compensation?

(a) In reaching a recommended decision with respect to EEOICPA compensation, OWCP considers the claim presented by the claimant, the factual and medical evidence of record, the dose reconstruction report calculated by HHS (if any), any report submitted by DOE and the results of such investigation as OWCP may deem necessary.

(b) The OWCP claims staff applies the law, the regulations and its procedures when it evaluates the medical evidence and the facts as reported or obtained upon investigation.

§ 30.306 What does the recommended decision contain?

The recommended decision shall contain findings of fact and conclusions of law. The recommended decision may accept or reject the claim in its entirety, or it may accept or reject a portion of the claim presented. It is accompanied by a notice of the claimant's right to file objections with, and request a hearing before, the FAB.

§ 30.307 To whom is the recommended decision sent?

(a) A copy of the recommended decision will be mailed to the claimant's last known address and to the claimant's designated representative before

OWCP, if any. Notification to either the claimant or the representative will be considered notification to both parties.

(b) At the same time it issues a recommended decision on a claim, the OWCP district office will forward the record of such claim to the FAB. Any new evidence submitted to the district office following the issuance of the recommended decision will also be forwarded to the FAB for consideration.

HEARINGS AND FINAL DECISIONS ON CLAIMS

§ 30.310 What must the claimant do if he or she objects to the recommended decision or wants to request a hearing?

(a) Within 60 days from the date the recommended decision is issued, the claimant must state, in writing, whether he or she objects to any of the findings of fact and/or conclusions of law contained in such decision, including HHS's reconstruction of the radiation dose to which the employee was exposed (if any), and whether a hearing is desired. This written statement should be filed with the FAB at the address indicated in the notice accompanying the recommended decision.

(b) For purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the FAB, the statement will be considered to be ''filed'' on the date that the claimant mails it to the FAB, as determined by postmark, or on the date that such written statement is actually received by the FAB, whichever is the earliest determinable date.

§ 30.311 What happens if the claimant does not object to the recommended decision or request a hearing within 60 days?

(a) If the claimant does not file a written statement that objects to the recommended decision and/or requests a hearing within the period of time allotted in § 30.310, the FAB may issue a final decision accepting the recommendation of the district office as provided in § 30.316.

(b) If the recommended decision accepts all or part of a claim for compensation, the FAB may issue a final decision at any time after receiving written notice from the claimant that he or she waives any objection to all or part of the recommended decision.

§ 30.312 What will the FAB do if the claimant objects to the recommended decision but does not request a hearing?

If the claimant files a written statement that objects to the recommended decision within the period of time allotted in § 30.310 but does not request a hearing, the FAB will consider any objections by means of a review of the written record. If the claimant only objects to part of the recommended decision, the FAB may issue a final decision accepting the remaining part of the recommendation of the district office without first reviewing the written record (see § 30.316).

§ 30.313 How is a review of the written record conducted?

(a) The FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

(b) The claimant should submit, with his or her written statement that objects to the recommended decision, all evidence or argument that he or she wants to present to the reviewer. However, evidence or argument may be submitted at any time up to the date specified by the reviewer for the submission of such evidence or argument.

(c) Any objection that is not presented to the FAB reviewer, including any objection to HHS's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

§ 30.314 How is a hearing conducted?

(a) The FAB reviewer retains complete discretion to set the time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved. At the discretion of the reviewer, the hearing may be conducted by telephone or teleconference. As part

of the hearing process, the FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

(1) The FAB reviewer will try to set the hearing at a place that is within commuting distance of the claimant's residence, but will not be able to do so in all cases. Therefore, for reasons of economy, the claimant may be required to travel a roundtrip distance of up to 200 miles to attend the hearing.

(2) In unusual circumstances, the FAB reviewer may set a place for the hearing that is more than 200 miles roundtrip from the claimant's residence. However, in that situation, OWCP will reimburse the claimant for reasonable and necessary travel expenses incurred to attend the hearing if he or she submits a written reimbursement request that documents such expenses.

(b) Unless otherwise directed in writing by the claimant, the FAB reviewer will mail a notice of the time and place of the hearing to the claimant and any representative at least 30 days before the scheduled hearing date. If the claimant only objects to part of the recommended decision, the FAB reviewer may issue a final decision accepting the remaining part of the recommendation of the district office without first holding a hearing (see § 30.316). Any objection that is not presented to the FAB reviewer, including any objection to HHS's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

(c) The hearing is an informal process, and the reviewer is not bound by common law or statutory rules of evidence, or by technical or formal rules of procedure. The reviewer may conduct the hearing in such manner as to best ascertain the rights of the claimant. During the hearing process, the claimant may state his or her arguments and present new written evidence and/or testimony in support of the claim.

(d) Testimony at hearings is recorded, then transcribed and placed in the record. Oral testimony shall be made under oath.

(e) The FAB reviewer will furnish a transcript of the hearing to the claimant, who has 20 days from the date it is sent to submit any comments to the reviewer.

(f) The claimant will have 30 days after the hearing is held to submit additional evidence or argument, unless the reviewer, in his or her sole discretion, grants an extension. Only one such extension may be granted.

(g) The reviewer determines the conduct of the hearing and may terminate the hearing at any time he or she determines that all relevant evidence has been obtained, or because of misbehavior on the part of the claimant and/or representative at or near the place of the oral presentation.

§ 30.315 May a claimant postpone a hearing?

(a) The FAB will entertain any reasonable request for scheduling the time and place of the hearing, but such requests should be made at the time that the hearing is requested. Scheduling is at the discretion of the FAB, and is not reviewable. In most instances, once the hearing has been scheduled and appropriate written notice has been mailed, it cannot be postponed at the claimant's request for any reason except those stated in paragraph (b) of this section, unless the FAB reviewer can reschedule the hearing on the same docket (that is, during the same hearing trip). If a request to postpone a scheduled hearing does not meet one of the tests of paragraph (b) of this section and cannot be accommodated on the same docket, no further opportunity for a hearing will be provided. Instead, the FAB will consider the claimant's objections by means of a review of the written record. In the alternative, a teleconference may be substituted for the hearing at the discretion of the reviewer.

(b) Where the claimant or the representative appointed by the claimant in accordance with § 30.600 of this part has a medical reason that prevents attendance at the hearing, or where the

death or illness of the claimant's parent , spouse, or child prevents the claimant from attending the hearing as scheduled, a postponement may be granted in the discretion of the FAB if the claimant or the representative provides at least 24 hours notice and a reasonable explanation supporting his or her inability to attend the scheduled hearing.

(c) At any time after requesting a hearing, the claimant can request a change to a review of the written record by making a written request to the FAB. Once such a change is made, no further opportunity for a hearing will be provided.

§ 30.316 How does the FAB issue a final decision on a claim?

(a) If the claimant does not file a written statement that objects to the recommended decision and/or requests a hearing within the period of time allotted in § 30.310, or if the claimant waives any objections to all or part of the recommended decision, the FAB may issue a final decision accepting the recommendation of the district office, either in whole or in part (see §§ 30.311, 30.312 and 30.314(b)).

(b) If the claimant objects to all or part of the recommended decision, the FAB reviewer will issue a final decision on the claim after either the hearing or the review of the written record, and after completing such further development of the case as he or she may deem necessary.

(c) Any recommended decision (or part thereof) that is pending either a hearing or a review of the written record for more than one year from the date the FAB received the written statement described in § 30.310(a), or the date the Director reopened the claim for issuance of a new final decision pursuant to § 30.320(a), shall be considered a final decision of the FAB on the one-year anniversary of such date. Any recommended decision described in § 30.311 that is pending at the FAB for more than one year from the date that the period of time described in § 30.310 expired shall be considered a final decision of the FAB on the one-year anniversary of such date.

(d) The decision of the FAB, whether issued pursuant to paragraph (a), (b) or (c) of this section, shall be final upon the date of issuance of such decision, unless a timely request for reconsideration under § 30.319 has been filed.

(e) A copy of the final decision of the FAB will be mailed to the claimant's last known address and to the claimant's designated representative before OWCP, if any. Notification to either the claimant or the representative will be considered notification to both parties.

§ 30.317 Can the FAB request a further response from the claimant or return a claim to the district office?

At any time before the issuance of its final decision, the FAB may request that the claimant submit additional evidence or argument, or return the claim to the district office for further development and/or issuance of a newly recommended decision without issuing a final decision, whether or not requested to do so by the claimant.

§ 30.318 Can the FAB consider objections to HHS's reconstruction of a radiation dose or to the guidelines OWCP uses to determine if a claimed cancer was at least as likely as not related to employment?

(a) If the claimant objects to HHS's reconstruction of the radiation dose to which the employee was exposed, the FAB will evaluate the factual findings upon which HHS based its dose reconstruction. If these factual findings do not appear to be supported by substantial evidence, the claim will be returned to the district office for referral to HHS for further consideration.

(b) The methodology used by HHS in arriving at reasonable estimates of the radiation doses received by an employee, established by regulations issued by HHS at 42 CFR part 82, is binding on the FAB. The FAB reviewer may determine, however, that objections concerning the application of that methodology should be considered by HHS and may return the case to the district office for referral to HHS for such consideration.

(c) The methodology that OWCP uses to determine if a claimed cancer was at least as likely as not related to employment at a DOE facility, an atomic weapons employer facility, or a RECA

section 5 facility, established by regulations issued by HHS at 42 CFR part 81, is also binding on the FAB (see § 30.213). However, since OWCP applies this methodology when it makes these determinations, the FAB reviewer may consider objections to the manner in which OWCP applied HHS's regulatory guidelines.

§ 30.319 May a claimant request reconsideration of a final decision of the FAB?

(a) A claimant may request reconsideration of a final decision of the FAB by filing a written request with the FAB within 30 days from the date of issuance of such decision. If a timely request for reconsideration is made, the decision in question will no longer be considered ''final'' under § 30.316(d).

(b) For purposes of determining whether the written request referred to in paragraph (a) of this section has been timely filed with the FAB, the request will be considered to be ''filed'' on the date that the claimant mails it to the FAB, as determined by postmark, or on the date that such written request is actually received by the FAB, whichever is the earliest determinable date.

(c) A hearing is not available as part of the reconsideration process. If the FAB grants the request for reconsideration, it will consider the written record of the claim again and issue a new final decision on the claim. A new final decision that is issued after the FAB grants a request for reconsideration will be ''final'' upon the date of issuance of such new decision.

(1) Instead of issuing a new final decision after granting a request for reconsideration, the FAB may return the claim to the district office for further development as provided in § 30.317.

(2) If the FAB denies the request for reconsideration, the FAB decision that formed the basis for the request will be considered ''final'' upon the date the request is denied, and no further requests for reconsideration of that particular final decision of the FAB will be entertained.

(d) A claimant may not seek judicial review of a decision on his or her claim under EEOICPA until OWCP's decision on the claim is final pursuant to either § 30.316(d) (for claims in which no request for reconsideration was filed with the FAB) or paragraph (c) of this section (for claims in which a request for reconsideration was filed with the FAB).

REOPENING CLAIMS

§ 30.320 Can a claim be reopened after the FAB has issued a final decision?

(a) At any time after the FAB has issued a final decision pursuant to § 30.316, and without regard to whether new evidence or information is presented or obtained, the Director for Energy Employees Occupational Illness Compensation may reopen a claim and return it to the FAB for issuance of a new final decision, or to the district office for such further development as may be necessary, to be followed by a new recommended decision. The Director may also vacate any other type of decision issued by the FAB.

(b) At any time after the FAB has issued a final decision pursuant to § 30.316, a claimant may file a written request that the Director for Energy Employees Occupational Illness Compensation reopen his or her claim, provided that the claimant also submits new evidence of either covered employment or exposure to a toxic substance, or identifies either a change in the PoC guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort.

(1) If the Director concludes that the evidence submitted or matter identified in support of the claimant's request is material to the claim, the Director will reopen the claim and return it to the district office for such further development as may be necessary, to be followed by a new recommended decision.

(2) New evidence of a medical condition described in subpart C of these regulations is not sufficient to support a written request to reopen a claim for such a condition under paragraph (b) of this section.

(c) The decision whether or not to reopen a claim under this section is solely within the discretion of the Director

for Energy Employees Occupational Illness Compensation and is not reviewable. If the Director reopens a claim pursuant to paragraphs (a) or (b) of this section and returns it to the district office, the resulting new recommended decision will be subject to the adjudicatory process described in this subpart. However, neither the district office nor the FAB can consider any objection concerning the Director's decision to reopen a claim under this section.

Subpart E—Medical and Related Benefits

MEDICAL TREATMENT AND RELATED ISSUES

§ 30.400 What are the basic rules for obtaining medical treatment?

(a) A covered Part B employee or a covered Part E employee who fits into at least one of the compensable claim categories described in subpart C of this part is entitled to receive all medical services, appliances or supplies that a qualified physician prescribes or recommends and that OWCP considers necessary to treat his or her occupational illness or covered illness, retroactive to the date the claim for benefits for that occupational illness or covered illness under Part B or Part E of EEOICPA was filed. In situations where the occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer; however, payment for medical treatment of the underlying primary cancer under these circumstances does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of EEOICPA. The employee need not be disabled to receive such treatment. When a survivor receives payment, OWCP will pay for such treatment if the employee died before the claim was paid. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the occupational illness or covered illness, the employee should consult OWCP prior to obtaining it.

(b) If a claimant disagrees with the decision of OWCP that medical benefits provided under paragraph (a) of this section are not necessary to treat an occupational illness or covered illness, he or she may choose to utilize the adjudicatory process described in subpart D of this part.

(c) Any qualified physician or qualified hospital may provide medical services, appliances and supplies to the covered Part B employee or the covered Part E employee. A qualified provider of medical support services may also furnish appropriate services, appliances, and supplies. OWCP may apply a test of cost-effectiveness when it decides if appliances and supplies are necessary to treat an occupational illness or covered illness. With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available.

§ 30.401 What are the special rules for the services of chiropractors?

(a) The services of chiropractors that may be reimbursed by OWCP are limited to treatment to correct a spinal subluxation. The costs of physical and related laboratory tests performed by or required by a chiropractor to diagnose such a subluxation are also payable.

(b) A diagnosis of spinal subluxation as demonstrated by x-ray to exist must appear in the chiropractor's report before OWCP can consider payment of a chiropractor's bill.

(c) A chiropractor may interpret his or her x-rays to the same extent as any other physician. To be given any weight, the medical report must state that x-rays support the finding of spinal subluxation. OWCP will not necessarily require submission of the x-ray, or a report of the x-ray, but the report must be available for submission on request.

(d) A chiropractor may also provide services in the nature of physical therapy under the direction of a qualified physician.

§ 30.402 What are the special rules for the services of clinical psychologists?

A clinical psychologist may serve as a physician within the scope of his or

her practice as defined by state law. Therefore, a clinical psychologist may not serve as a physician for conditions that include a physical component unless the applicable state law allows clinical psychologists to treat physical conditions. A clinical psychologist may also perform testing, evaluation, and other services under the direction of a qualified physician.

§ 30.403 Will OWCP pay for the services of an attendant?

OWCP will authorize payment for personal care services under section 7384t of the Act, whether or not such care includes medical services, so long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual. If a claimant disagrees with the decision of OWCP that personal care services are not medically necessary, he or she may utilize the adjudicatory process described in subpart D of this part.

§ 30.404 Will OWCP pay for transportation to obtain medical treatment?

(a) The employee is entitled to reimbursement for reasonable and necessary expenses, including transportation, incident to obtaining authorized medical services, appliances or supplies. To determine what is a reasonable distance to travel, OWCP will consider the availability of services, the employee's condition, and the means of transportation. Generally, a roundtrip distance of up to 200 miles is considered a reasonable distance to travel.

(b) If travel of more than 200 miles is contemplated, or air transportation or overnight accommodations will be needed, the employee must submit a written request to OWCP for prior authorization with information describing the circumstances and necessity for such travel expenses. OWCP will approve the request if it determines that the travel expenses are reasonable and necessary, and are incident to obtaining authorized medical services, appliances or supplies. Requests for travel expenses that are often approved include those resulting from referrals to a specialist for further medical treatment, and those involving air transportation of an employee who lives in a remote geographical area with limited local medical services.

(c) If a claimant disagrees with the decision of OWCP that requested travel expenses are either not reasonable or necessary, or are not incident to obtaining authorized medical services, appliances or supplies, he or she may utilize the adjudicatory process described in subpart D of this part.

(d) The standard form designated for medical travel refund requests is Form OWCP–957 and must be used to seek reimbursement under this section. This form can be obtained from OWCP.

§ 30.405 After selecting a treating physician, may an employee choose to be treated by another physician instead?

(a) OWCP will provide the employee with an opportunity to designate a treating physician when it accepts the claim. When the physician originally selected to provide treatment for an occupational illness or a covered illness refers the employee to a specialist for further medical care, the employee need not consult OWCP for approval. In all other instances, however, the employee must submit a written request to OWCP with his or her reasons for desiring a change of physician.

(b) OWCP will approve the request if it determines that the reasons submitted are sufficient. Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating the occupational illnesses or covered illnesses covered by EEOICPA, or the need for a new physician when an employee has moved.

(c) If a claimant disagrees with the decision of OWCP that insufficient reasons for a change of physician have been submitted, he or she may utilize the adjudicatory process described in subpart D of this part.

§ 30.406 Are there any exceptions to these procedures for obtaining medical care?

In cases involving emergencies or unusual circumstances, OWCP may authorize treatment in a manner other than as stated in this subpart.

DIRECTED MEDICAL EXAMINATIONS

§ 30.410 Can OWCP require an employee to be examined by another physician?

(a) OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP as often and at such times and places as OWCP considers reasonably necessary. Also, OWCP may send a case file for second opinion review to a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP where an actual examination is not needed, or where the employee is deceased.

(b) If the initial examination is disrupted by someone accompanying the employee, OWCP will schedule another examination with a different qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP. The employee will not be entitled to have anyone else present at the subsequent examination unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed.

§ 30.411 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

(a) If one medical opinion holds more probative value than the other, OWCP will base its determination of coverage on the medical opinion with the greatest probative value. A difference in medical opinion sufficient to be considered a conflict only occurs when two reports of virtually equal weight and rationale reach opposing conclusions.

(b) If a conflict exists between the medical opinion of the employee's physician and the medical opinion of a second opinion physician, an OWCP medical adviser or consultant, or a physician submitting an impairment evaluation that meets the criteria set out in § 30.905 of this part, OWCP shall appoint a third physician who conforms to the standards regarding conflicts of interest adopted by OWCP to make an examination or an impairment evaluation. This is called a referee examination or a referee impairment evaluation. OWCP will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case. Also, a case file may be sent to a physician who conforms to the standards regarding conflicts of interest adopted by OWCP for a referee medical review where there is no need for an actual examination, or where the employee is deceased.

(c) If the initial referee examination or referee impairment evaluation is disrupted by someone accompanying the employee, OWCP will schedule another examination or impairment evaluation with a different qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP. The employee will not be entitled to have anyone else present at the subsequent referee examination or referee impairment evaluation unless OWCP decides that exceptional circumstances exist. For example, where a hearing-impaired employee needs an interpreter, the presence of an interpreter would be allowed.

§ 30.412 Who pays for second opinion and referee examinations?

OWCP will pay second opinion and referee medical specialists directly. OWCP will also reimburse the employee for all necessary and reasonable expenses incident to such an examination, including transportation costs and actual wages the employee lost for the time needed to submit to an examination required by OWCP.

MEDICAL REPORTS

§ 30.415 What are the requirements for medical reports?

In general, medical reports from the employee's attending physician should include the following:

(a) Dates of examination and treatment;

(b) History given by the employee;

(c) Physical findings;

(d) Results of diagnostic tests;

(e) Diagnosis;

(f) Course of treatment;

(g) A description of any other conditions found due to the claimed occupational illness or covered illness;

(h) The treatment given or recommended for the claimed occupational illness or covered illness; and

(i) All other material findings.

§ 30.416 How and when should medical reports be submitted?

(a) The initial medical report (and any subsequent reports) should be made in narrative form on the physician's letterhead stationery. The physician should use the Form EE–7 as a guide for the preparation of his or her initial medical report in support of a claim under Part B and/or Part E of EEOICPA. The report should bear the physician's signature or signature stamp. OWCP may require an original signature on the report.

(b) The report shall be submitted directly to OWCP as soon as possible after medical examination or treatment is received, either by the employee or the physician.

§ 30.417 What additional medical information may OWCP require to support continuing payment of benefits?

In all cases requiring hospital treatment or prolonged care, OWCP will request detailed narrative reports from the attending physician at periodic intervals. The physician will be asked to describe continuing medical treatment for the occupational illness or covered illness accepted by OWCP, a prognosis, and the physician's opinion as to the continuing causal relationship between the need for additional treatment and the occupational illness or covered illness.

MEDICAL BILLS

§ 30.420 How should medical bills and reimbursement requests be submitted?

Usually, medical providers submit their bills directly for processing. The rules for submitting and processing provider bills and reimbursement requests are stated in subpart H of this part. An employee requesting reimbursement for out-of-pocket medical expenses must submit a Form OWCP–915 and meet the requirements described in § 30.702.

§ 30.421 What are the time frames for submitting bills and reimbursement requests?

To be considered for payment, bills and reimbursement requests must be submitted by the end of the calendar year after the year when the expense was incurred, or by the end of the calendar year after the year when OWCP first accepted the claim as compensable under subpart D of this part, whichever is later.

§ 30.422 If an employee is only partially reimbursed for a medical expense, must the provider refund the balance of the amount paid to the employee?

(a) The OWCP fee schedule sets maximum limits on the amounts payable for many services. The employee may be only partially reimbursed for out-of-pocket medical expenses because the amount he or she paid to the medical provider for a service exceeds the maximum allowable charge set by the OWCP fee schedule.

(b) If this happens, the employee will be advised of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid that exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(c) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge that OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

Subpart F—Survivors; Payments and Offsets; Overpayments

SURVIVORS

§ 30.500 What special statutory definitions apply to survivors under EEOICPA?

(a) For the purposes of paying compensation to survivors under both Parts B and E of EEOICPA, OWCP will use the following definitions:

(1) *Surviving spouse* means the wife or husband of a deceased covered Part B employee or deceased covered Part E employee who was married to that individual for the 365 consecutive days immediately prior to the death of that individual.

(2) *Child* or *children* includes a recognized natural child of a deceased covered Part B employee or deceased covered Part E employee, a stepchild who lived with that individual in a regular parent-child relationship, and an adopted child of that individual. However, to be a ''covered'' child under Part E only, such child must have been, as of the date of the deceased covered Part E employee's death, either under the age of 18 years, or under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support.

(b) For the purposes of paying compensation to survivors only under Part B of EEOICPA, OWCP will use the following additional definitions:

(1) *Parent* includes fathers and mothers of a deceased covered Part B employee through adoption.

(2) *Grandchild* means a child of a child of a deceased covered Part B employee.

(3) *Grandparent* means a parent of a parent of a deceased covered Part B employee.

§ 30.501 What order of precedence will OWCP use to determine which survivors are entitled to receive compensation under EEOICPA?

(a) Under Part B of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part B employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(gg)(3) of these regulations:

(1) If there is a surviving spouse, the compensation shall be paid to that individual.

(2) If there is no surviving spouse, the compensation shall be paid in equal shares to all children of the deceased covered Part B employee.

(3) If there is no surviving spouse and no children, the compensation shall be paid in equal shares to the parents of the deceased covered Part B employee.

(4) If there is no surviving spouse, no children and no parents, the compensation shall be paid in equal shares to all grandchildren of the deceased covered Part B employee.

(5) If there is no surviving spouse, no children, no parents and no grandchildren, the compensation shall be paid in equal shares to the grandparents of the deceased covered Part B employee.

(6) Notwithstanding paragraphs (a)(1) through (a)(5) of this section, if there is a surviving spouse and at least one child of the deceased covered Part B employee who is a minor at the time of payment and who is not a recognized natural child or adopted child of such surviving spouse, half of the compensation shall be paid to the surviving spouse, and the other half of the compensation shall be paid in equal shares to each child of the deceased covered Part B employee who is a minor at the time of payment.

(b) Under Part E of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part E employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(gg)(3) of these regulations:

(1) If there is a surviving spouse, the compensation shall be paid to that individual.

(2) If there is no surviving spouse, the compensation shall be paid in equal shares to all ''covered'' children of the deceased covered Part E employee.

(3) Notwithstanding paragraphs (b)(1) and (b)(2) of this section, if there is a surviving spouse and at least one ''covered'' child of the deceased covered Part E employee who is living at the time of payment and who is not a recognized natural child or adopted child of such surviving spouse, then half of such payment shall be made to such surviving spouse, and the other half of such payment shall be made in equal shares to each ''covered'' child of the employee who is living at the time of payment.

§ 30.502 When is entitlement for survivors determined for purposes of EEOICPA?

Entitlement to any lump-sum payment for survivors under EEOICPA, other than for ''covered'' children under Part E, will be determined as of the time OWCP makes such a payment. As noted in § 30.500(a)(2) of these regulations, a child of a deceased Part E employee will only qualify as a ''covered'' child of that individual if he or she satisfied one of the additional statutory criteria for a ''covered'' child as of the date of the deceased Part E employee's death.

Payment of Claims and Offset for Certain Payments

§ 30.505 What procedures will OWCP follow before it pays any compensation?

(a) In cases involving the approval of a claim, whether in whole or in part, OWCP shall take all necessary steps to determine the amount of any offset or coordination of EEOICPA benefits before paying any benefits, and to verify the identity of the covered Part B employee, the covered Part E employee, or the eligible surviving beneficiary or beneficiaries. To perform these tasks, OWCP may conduct any investigation, require any claimant to provide or execute any affidavit, record or document, or authorize the release of any information as OWCP deems necessary to ensure that the compensation payment is made in the correct amount and to the correct person or persons. OWCP shall also require every claimant under Part B of the Act to execute and provide any necessary affidavit described in § 30.620 of these regulations. Should a claimant fail or refuse to execute an affidavit or release of information, or fail or refuse to provide a requested document or record or to provide access to information, such failure or refusal may be deemed to be a rejection of the payment, unless the claimant does not have and cannot obtain the legal authority to provide, release, or authorize access to the required information, records, or documents.

(b) To determine the amount of any offset, OWCP shall require the covered Part B employee, covered Part E employee or each eligible surviving beneficiary filing a claim under this part to execute and provide an affidavit (or declaration made under oath on Form EE–1 or EE–2) reporting the amount of any payment made pursuant to a final judgment or settlement in litigation seeking damages. Even if someone other than the covered Part B employee or the covered Part E employee receives a payment pursuant to a final judgment or settlement in litigation seeking damages (*e.g.*, the surviving spouse of a deceased covered Part B employee or a deceased covered Part E employee), the receipt of any such payment must be reported.

(1) For the purposes of this paragraph (b) only, ''litigation seeking damages'' refers to any request or demand for money (other than for workers' compensation) by the covered Part B employee or the covered Part E employee, or by another individual if the covered Part B employee or the covered Part E employee is deceased, made or sought in a civil action or in anticipation of the filing of a civil action, for injuries incurred on account of an exposure for which compensation is payable under EEOICPA. This term does not also include any request or demand for money made or sought pursuant to a life insurance or health insurance contract, or any request or demand for money made or sought by an individual other than the covered Part B employee or the covered Part E employee in that individual's own right (*e.g.*, a spouse's claim for loss of consortium), or any request or demand for money made or sought by the covered Part B employee or the covered Part E employee (or the

estate of a deceased covered Part B employee or deceased covered Part E employee) not for injuries incurred on account of an exposure for which compensation is payable under the EEOICPA (*e.g.*, a covered Part B employee's or a covered Part E employee's claim for damage to real or personal property).

(2) If a payment has been made pursuant to a final judgment or settlement in litigation seeking damages, OWCP shall subtract a portion of the dollar amount of such payment from the benefit payments to be made under EEOICPA. OWCP will calculate the amount to be subtracted from the benefit payments in the following manner:

(i) OWCP will first determine the value of the payment made pursuant to either a final judgment or settlement in litigation seeking damages by adding the dollar amount of any monetary damages (excluding contingent awards) and any medical expenses for treatment provided on or after the date the covered Part B employee or the covered Part E employee filed a claim for EEOICPA benefits that were paid for under the final judgment or settlement. In the event that these payments include a ''structured'' settlement (where a party makes an initial cash payment and also arranges, usually through the purchase of an annuity, for payments in the future), OWCP will usually accept the cost of the annuity to the purchaser as the dollar amount of the right to receive the future payments.

(ii) OWCP will then make certain deductions from the above dollar amount to arrive at the dollar amount to be subtracted from any unpaid EEOICPA benefits. Allowable deductions consist of attorney's fees OWCP deems reasonable, and itemized costs of suit (out-of-pocket expenditures not part of the normal overhead of a law firm's operation like filing fees, travel expenses, witness fees, and court reporter costs for transcripts) provided that adequate supporting documentation is submitted to OWCP.

(iii) The EEOICPA benefits that will be reduced will consist of any unpaid lump-sum payments payable in the future and medical benefits payable in the future. In those cases where it has not yet paid EEOICPA benefits, OWCP will reduce such benefits on a dollar-for-dollar basis, beginning with the lump-sum payments first. If the amount to be subtracted exceeds the lump-sum payments, OWCP will reduce ongoing EEOICPA medical benefits payable in the future by the amount of any remaining surplus. This means that OWCP will apply the amount it would otherwise pay to reimburse the covered Part B employee or the covered Part E employee for any ongoing EEOICPA medical treatment to the remaining surplus until it is absorbed. In addition to this reduction of ongoing EEOICPA medical benefits, OWCP will not be the first payer for any medical expenses that are the responsibility of another party (who will instead be the first payer) as part of a final judgment or settlement in litigation seeking damages.

(3) The above reduction of EEOICPA benefits will not occur if an EEOICPA claimant had his or her award under section 5 of RECA reduced by the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages. It will also not occur if an EEOICPA claimant's prior payment of EEOICPA benefits, or his or her workers' compensation benefits, were offset to reflect the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages. However, if the prior reduction or offset of the above benefits did not reflect the full amount of the payment made pursuant to a final judgment or settlement in litigation seeking damages, OWCP will reduce currently payable EEOICPA benefits by the amount of any surplus final judgment or settlement payment that remains.

(c) Except as provided in § 30.506(b) of these regulations, when OWCP has verified the identity of every claimant who is entitled to the compensation payment, or to a share of the compensation payment, and has determined the correct amount of the payment or the share of the payment, OWCP shall notify every claimant, every duly appointed guardian or conservator of a claimant, or every person with power of attorney for a claimant, and require such person or persons to

complete a Form EN–20 providing payment information. Such form shall be signed and returned to OWCP within sixty days of the date of the form or within such greater period as may be allowed by OWCP. Failure to sign and return the form within the required time may be deemed to be a rejection of the payment. If the claimant dies before the payment is received, the person who receives the payment shall return it to OWCP for redetermination of the correct disbursement of the payment. No payment shall be made until OWCP has made a determination concerning the survivors related to a respective claim for benefits.

(d) The total amount of compensation (other than medical benefits) under Part E that can be paid to all claimants as a result of the exposure of a covered Part E employee shall not be more than $250,000 in any circumstances.

§ 30.506 To whom and in what manner will OWCP pay compensation?

(a) Except with respect to claims under Part B of the Act for beryllium sensitivity, payment shall be made to the covered Part B employee or the covered Part E employee, to the duly appointed guardian or conservator of that individual, or to the person with power of attorney for that individual, unless the covered Part B employee or covered Part E employee is deceased at the time of the payment. In all cases involving a deceased covered Part B employee or deceased covered Part E employee, payment shall be made to the eligible surviving beneficiary or beneficiaries, to the duly appointed guardian or conservator of the eligible surviving beneficiary or beneficiaries, or to every person with power of attorney for an eligible surviving beneficiary, in accordance with the terms and conditions specified in sections 7384s(e), 7384u(e), and 7385s–3(c) and (d) of EEOICPA.

(b) Under Part B of the Act, compensation for any consequential injury, illness, impairment or disease is limited to payment of medical benefits for that injury, illness, impairment or disease. Under Part E of the Act, compensation for any consequential injury, illness, impairment or disease consists of medical benefits for that injury, illness, impairment or disease, as well as any additional monetary benefits that are consistent with the terms of § 30.505(d).

(c) Rejected compensation payments, or shares of compensation payments, shall not be distributed to other eligible surviving beneficiaries, but shall be returned to the Fund.

(d) No covered Part B employee may receive more than one lump-sum payment under Part B of EEOICPA for any occupational illnesses he or she contracted. However, any individual, including a covered Part B employee who has received a lump-sum payment for his or her own occupational illness or illnesses, may receive one lump-sum payment for each deceased covered Part B employee for whom he or she qualifies as an eligible surviving beneficiary under Part B of the Act.

§ 30.507 What compensation will be provided to covered Part B employees who only establish beryllium sensitivity under Part B of EEOICPA?

The establishment of beryllium sensitivity does not entitle a covered Part B employee, or the eligible surviving beneficiary or beneficiaries of a deceased covered Part B employee, to any lump-sum payment provided for under Part B. Instead, a covered Part B employee whose sole accepted occupational illness is beryllium sensitivity shall receive beryllium sensitivity monitoring, as well as medical benefits for the treatment of this occupational illness in accordance with § 30.400 of these regulations.

§ 30.508 What is beryllium sensitivity monitoring?

Beryllium sensitivity monitoring shall consist of medical examinations to confirm and monitor the extent and nature of a covered Part B employee's beryllium sensitivity. Monitoring shall also include regular medical examinations, with diagnostic testing, to determine if the covered Part B employee has established chronic beryllium disease.

§ 30.509 Under what circumstances may a survivor claiming under Part E of the Act choose to receive the benefits that would otherwise be payable to a covered Part E employee who is deceased?

(a) If a covered Part E employee dies after filing a claim but before monetary benefits are paid under Part E of the Act, and his or her death is from a cause other than a covered illness, his or her survivor can choose to receive either the survivor benefits payable on account of the death of that covered Part E employee, or the monetary benefits that would otherwise have been payable to the covered Part E employee.

(b) For the purposes of this section only, a death ''from a cause other than a covered illness'' refers only to a death that was *solely* caused by a non-covered illness or illnesses. Therefore, the choice referred to in paragraph (a) of this section will not be available if a covered illness contributed to the death of the covered Part E employee in any manner. In those instances, survivor benefits will still be payable to the claimant, but he or she cannot choose to receive the monetary benefits that would have otherwise been payable to the deceased covered Part E employee in lieu of survivor benefits.

(c) OWCP only makes impairment determinations based on rationalized medical evidence in the case file that is sufficiently detailed and meets the various requirements for the many different types of impairment determinations possible under the AMA's *Guides*. Therefore, OWCP will only make an impairment determination for a deceased covered Part E employee pursuant to this section if the medical evidence of record is sufficient to satisfy the pertinent requirements in the AMA's *Guides* and subpart J of this part.

OVERPAYMENTS

§ 30.510 How does OWCP notify an individual of a payment made on a claim?

(a) In addition to providing narrative descriptions to recipients of benefits paid or payable, OWCP includes on each check a clear indication of the reason the payment is being made. For payments sent by electronic funds transfer, a notification of the date and amount of payment appears on the statement from the recipient's financial institution.

(b) By these means, OWCP puts the recipient on notice that a payment was made and the amount of the payment. If the amount received differs from the amount indicated on the written notice or bank statement, the recipient is responsible for notifying OWCP of the difference. Absent affirmative evidence to the contrary, the recipient will be presumed to have received the notice of payment, whether mailed or transmitted electronically.

§ 30.511 What is an "overpayment" for purposes of EEOICPA?

An ''overpayment'' is any amount of compensation paid under sections 7384s, 7384t, 7384u, 7385s–2 or 7385s–3 of the EEOICPA to a recipient that constitutes, as of the time OWCP makes such payment:

(a) Payment where no amount is payable under this part; or

(b) Payment in excess of the correct amount determined by OWCP.

§ 30.512 What does OWCP do when an overpayment is identified?

Before seeking to recover an overpayment or adjust benefits, OWCP will advise the recipient of the overpayment in writing that:

(a) The overpayment exists, and the amount of overpayment;

(b) A preliminary finding shows either that the recipient was or was not at fault in the creation of the overpayment;

(c) He or she has the right to inspect and copy OWCP records relating to the overpayment; and

(d) He or she has the right to present written evidence which challenges the fact or amount of the overpayment, and/or challenges the preliminary finding that he or she was at fault in the creation of the overpayment. He or she may also request that recovery of the overpayment be waived. Any submission of evidence or request that recovery of the overpayment be waived must be presented to OWCP within 30 days of the date of the written notice of overpayment.

§ 30.513 Under what circumstances may OWCP waive recovery of an overpayment?

(a) OWCP may consider waiving recovery of an overpayment only if the recipient was not at fault in accepting or creating the overpayment. Recipients of benefits paid under EEOICPA are responsible for taking all reasonable measures to ensure that payments received from OWCP are proper. The recipient must show good faith and exercise a high degree of care in reporting events which may affect entitlement to or the amount of benefits. A recipient who has done any of the following will be found to be at fault with respect to creating an overpayment:

(1) Made an incorrect statement as to a material fact which he or she knew or should have known to be incorrect; or

(2) Failed to provide information which he or she knew or should have known to be material; or

(3) Accepted a payment which he or she knew or should have known to be incorrect. (This provision applies only to the overpaid individual.)

(b) Whether or not OWCP determines that a recipient was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the recipient's capacity to realize that he or she is being overpaid.

§ 30.514 If OWCP finds that the recipient of an overpayment was not at fault, what criteria are used to decide whether to waive recovery of it?

If OWCP finds that the recipient of an overpayment was not at fault, repayment will still be required unless:

(a) Adjustment or recovery of the overpayment would defeat the purpose of the Act (see § 30.516); or

(b) Adjustment or recovery of the overpayment would be against equity and good conscience (see § 30.517).

§ 30.515 Is a recipient responsible for an overpayment that resulted from an error made by OWCP?

(a) The fact that OWCP may have erred in making the overpayment does not by itself relieve the recipient of the overpayment from liability for repayment if the recipient also was at fault in accepting the overpayment.

(b) However, OWCP may find that the recipient was not at fault if failure to report an event affecting compensation benefits, or acceptance of an incorrect payment, occurred because:

(1) The recipient relied on misinformation given in writing by OWCP regarding the interpretation of a pertinent provision or EEOICPA of this part; or

(2) OWCP erred in calculating either the percentage of impairment or wage-loss under Part E of EEOICPA.

§ 30.516 Under what circumstances would recovery of an overpayment defeat the purpose of the Act?

Recovery of an overpayment will defeat the purpose of the Act if such recovery would cause hardship to the recipient because:

(a) The recipient from whom OWCP seeks recovery needs substantially all of his or her current income to meet current ordinary and necessary living expenses; and

(b) The recipient's assets do not exceed two months' expenditures as determined by OWCP using the Bureau of Labor Statistics Consumer Expenditure Survey tables.

§ 30.517 Under what circumstances would recovery of an overpayment be against equity and good conscience?

(a) Recovery of an overpayment is considered to be against equity and good conscience when the recipient would experience severe financial hardship in attempting to repay the debt.

(b) Recovery of an overpayment is also considered to be against equity and good conscience when the recipient, in reliance on such payments or on notice that such payments would be made, gives up a valuable right or changes his or her position for the worse. In making such a decision, OWCP does not consider the recipient's current ability to repay the overpayment.

(1) To establish that a valuable right has been relinquished, it must be shown that the right was in fact valuable, that it cannot be regained, and

that the action was based chiefly or solely in reliance on the payments or on the notice of payment. Gratuitous transfers of funds to other individuals are not considered relinquishments of valuable rights.

(2) To establish that a recipient's position has changed for the worse, it must be shown that the decision made would not otherwise have been made but for the receipt of benefits, and that this decision resulted in a loss.

§ 30.518 Can OWCP require the recipient of the overpayment to submit additional financial information?

(a) The recipient of the overpayment is responsible for providing information about income, expenses and assets as specified by OWCP. This information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the Act, or would be against equity and good conscience. This information will also be used to determine the repayment schedule, if necessary.

(b) Failure to submit this requested information within 30 days of the request shall result in denial of waiver, and no further request for waiver shall be considered until the requested information is furnished.

§ 30.519 How does OWCP communicate its final decision concerning recovery of an overpayment?

(a) After considering any written documentation or argument submitted to OWCP within the 30-day period set out in §30.512(d), OWCP will issue a final decision on the overpayment. OWCP will send a copy of the final decision to the individual from whom recovery is sought and his or her representative, if any.

(b) The provisions of subpart D of this part do not apply to any decision regarding the recovery of an overpayment.

§ 30.520 How are overpayments collected?

(a) When an overpayment has been made to a recipient who is entitled to further payments, the recipient shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. If no refund is made, OWCP shall recover the overpayment by reducing any further lump-sum payments due currently or in the future, taking into account the financial circumstances of the recipient, and any other relevant factors, so as to minimize any hardship. Should the recipient die before collection has been completed, further collection shall be made by decreasing later payments, if any, payable under EEOICPA with respect to the underlying occupational illness or covered illness.

(b) When an overpayment has been made to a recipient and OWCP is unable to recover the overpayment by reducing compensation due currently, the recipient shall refund to OWCP the amount of the overpayment as soon as the error is discovered or his or her attention is called to same. The overpayment is subject to the provisions of the Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et seq.*), and may be reported to the Internal Revenue Service as income. If the recipient fails to make such refund, OWCP may recover the overpayment through any available means, including offset of salary, annuity benefits, or other Federal payments, including tax refunds as authorized by the Tax Refund Offset Program, or referral of the debt to a collection agency or to the Department of Justice.

Subpart G—Special Provisions

REPRESENTATION

§ 30.600 May a claimant designate a representative?

(a) The claims process under this part is informal, and OWCP acts as an impartial evaluator of the evidence. A claimant need not be represented to file a claim or receive a payment. Nevertheless, a claimant may appoint one individual to represent his or her interests, but the appointment must be in writing.

(b) There can be only one representative at any one time, so after one representative has been properly appointed, OWCP will not recognize another individual as a representative until the claimant withdraws the authorization of the first individual. In

addition, OWCP will recognize only certain types of individuals (see § 30.601). For the purposes of paragraph (b) of this section, a ''representative'' does not include a person who only has a power of attorney to act on behalf of a claimant.

(c) A properly appointed representative who is recognized by OWCP may make a request or give direction to OWCP regarding the claims process, including a hearing. This authority includes presenting or eliciting evidence, making arguments on facts or the law, and obtaining information from the case file, to the same extent as the claimant.

(1) Any notice requirement contained in this part or EEOICPA is fully satisfied if served on the representative, and has the same force and effect as if sent to the claimant.

(2) A representative does not have authority to sign the Form EN–20, described in § 30.505(c) of these regulations, which collects information necessary for issuance of a compensation payment.

§ 30.601 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under EEOICPA, unless that individual's service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and 208). A federal employee may act as a representative only:

(a) On behalf of immediate family members, defined as a spouse, children, parents, and siblings of the representative, provided no fee or gratuity is charged; or

(b) While acting as a union representative, defined as any officially sanctioned union official, and no fee or gratuity is charged.

§ 30.602 Who is responsible for paying the representative's fee?

A representative may charge the claimant a fee for services and for costs associated with the representation before OWCP. The claimant is solely responsible for paying the fee and other costs. OWCP will not reimburse the claimant, nor is it in any way liable for the amount of the fee and costs.

§ 30.603 Are there any limitations on what the representative may charge the claimant for his or her services?

(a) Notwithstanding any contract, the representative may not receive, for services rendered in connection with a claim pending before OWCP, more than the percentages of the lump-sum payment made to the claimant set out in paragraph (b) of this section.

(b) The percentages referred to in paragraph (a) of this section are:

(1) 2 percent for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus

(2) 10 percent of the difference between the lump-sum payment made to the claimant and the amount proposed in the recommended decision with respect to objections to a recommended decision.

(c)(1) Any representative who violates this section shall be fined not more than $5,000.

(2) The authority to prosecute violations of this limitation lies with the Department of Justice.

(d) The fee limitations described in this section shall not apply with respect to representative services that are rendered in connection with a petition filed with a U.S. District Court seeking review of an OWCP decision that is final pursuant to § 30.316(d), or with respect to any subsequent appeal in such a proceeding.

THIRD PARTY LIABILITY

§ 30.605 What rights does the United States have upon payment of compensation under EEOICPA?

If an occupational illness or covered illness for which compensation is payable under EEOICPA is caused, wholly or partially, by someone other than a federal employee acting within the scope of his or her employment, a DOE contractor or subcontractor, a beryllium vendor, an atomic weapons employer or a RECA section 5 mine or mill, the United States is subrogated for the full amount of any payment of compensation under EEOICPA to any right or claim that the individual to whom the payment was made may have

against any person or entity on account of such occupational illness or covered illness.

§ 30.606 Under what circumstances must a recovery of money or other property in connection with an illness for which benefits are payable under EEOICPA be reported to OWCP?

Any person who has filed an EEOICPA claim that has been accepted by OWCP (whether or not compensation has been paid), or who has received EEOICPA benefits in connection with a claim filed by another, is required to notify OWCP of the receipt of money or other property as a result of a settlement or judgment in connection with the circumstances of that claim.

§ 30.607 How is a structured settlement (that is, a settlement providing for receipt of funds over a specified period of time) treated for purposes of reporting the recovery?

In this situation, the recovery to be reported is the present value of the right to receive all of the payments included in the structured settlement, allocated in the case of multiple recipients in the same manner as single payment recoveries.

§ 30.608 How does the United States calculate the amount to which it is subrogated?

The subrogated amount of a specific claim consists of the total money paid by OWCP from the Energy Employees Occupational Illness Compensation Fund with respect to that claim to or on behalf of a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary, less charges for any medical file review (*i.e.*, the physician did not examine the employee) done at the request of OWCP. Charges for medical examinations also may be subtracted if the covered Part B employee, covered Part E employee or an eligible surviving beneficiary establishes that the examinations were required to be made available to the covered Part B employee or covered Part E employee under a statute other than EEOICPA.

§ 30.609 Is a settlement or judgment received as a result of allegations of medical malpractice in treating an illness covered by EEOICPA a recovery that must be reported to OWCP?

Since an injury caused by medical malpractice in treating an occupational illness or covered illness compensable under EEOICPA is also covered under EEOICPA, any recovery in a suit alleging such an injury is treated as a recovery that must be reported to OWCP.

§ 30.610 Are payments to a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary as a result of an insurance policy which the employee or eligible surviving beneficiary has purchased a recovery that must be reported to OWCP?

Since payments received by a covered Part B employee, a covered Part E employee or an eligible surviving beneficiary pursuant to an insurance policy purchased by someone other than a liable third party are not payments in satisfaction of liability for causing an occupational illness or covered illness compensable under the Act, they are not considered a recovery that must be reported to OWCP.

§ 30.611 If a settlement or judgment is received for more than one medical condition, can the amount paid on a single EEOICPA claim be attributed to different conditions for purposes of calculating the amount to which the United States is subrogated?

(a) All medical conditions accepted by OWCP in connection with a single claim are treated as the same illness for the purpose of computing the amount which the United States is entitled to offset in connection with the receipt of a recovery from a third party, except that an injury caused by medical malpractice in treating an illness covered under EEOICPA will be treated as a separate injury.

(b) If an illness covered under EEOICPA is caused under circumstances creating a legal liability in more than one person, other than the United States, a DOE contractor or subcontractor, a beryllium vendor or an atomic weapons employer, to pay

damages, OWCP will determine whether recoveries received from one or more third parties should be attributed to separate conditions for which compensation is payable in connection with a single EEOICPA claim. If such an attribution is both practicable and equitable, as determined by OWCP, in its discretion, the conditions will be treated as separate injuries for purposes of calculating the amount to which the United States is subrogated.

EFFECT OF TORT SUITS AGAINST BERYLLIUM VENDORS AND ATOMIC WEAPONS EMPLOYERS

§ 30.615 What type of tort suits filed against beryllium vendors or atomic weapons employers may disqualify certain claimants from receiving benefits under Part B of EEOICPA?

(a) A tort suit (other than an administrative or judicial proceeding for workers' compensation) that includes a claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation, filed against a beryllium vendor or an atomic weapons employer, by a covered Part B employee or an eligible surviving beneficiary or beneficiaries of a deceased covered Part B employee, will disqualify that otherwise eligible individual or individuals from receiving benefits under Part B of EEOICPA unless such claim is terminated in accordance with the requirements of §§ 30.616 through 30.619 of these regulations.

(b) The term ''claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation'' used in paragraph (a) of this section includes a claim that is derivative of a covered Part B employee's employment-related exposure to beryllium or radiation, such as a claim for loss of consortium raised by a covered Part B employee's spouse.

(c) If all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation are terminated in accordance with the requirements of §§ 30.616 through 30.619 of these regulations, proceeding with the remaining portion of the tort suit filed against a beryllium vendor or an atomic weapons employer will not disqualify an otherwise eligible individual or individuals from receiving benefits under Part B of EEOICPA.

§ 30.616 What happens if this type of tort suit was filed prior to October 30, 2000?

(a) If a tort suit described in § 30.615 was filed prior to October 30, 2000, the claimant or claimants will not be disqualified from receiving any EEOICPA benefits to which they may be found entitled if the tort suit was terminated in any manner prior to December 28, 2001.

(b) If a tort suit described in § 30.615 was filed prior to October 30, 2000 and was pending as of December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under Part B of EEOICPA unless they dismissed all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that were included in the tort suit prior to December 31, 2003.

§ 30.617 What happens if this type of tort suit was filed during the period from October 30, 2000 through December 28, 2001?

(a) If a tort suit described in § 30.615 was filed during the period from October 30, 2000 through December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under Part B of EEOICPA unless they dismiss all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that are included in the tort suit on or before the last permissible date described in paragraph (b) of this section.

(b) The last permissible date is the later of:

(1) April 30, 2003; or

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, ''the date the claimant or claimants first became aware'' will be deemed to be the date they received either a reconstructed dose from HHS, or a diagnosis

of a covered beryllium illness, as applicable.

§ 30.618 What happens if this type of tort suit was filed after December 28, 2001?

(a) If a tort suit described in § 30.615 was filed after December 28, 2001, the claimant or claimants will be disqualified from receiving any benefits under Part B of EEOICPA if a judgment is entered against them.

(b) If a tort suit described in § 30.615 was filed after December 28, 2001 and a judgment has not yet been entered against the claimant or claimants, they will also be disqualified from receiving any benefits under Part B of EEOICPA unless, prior to entry of any judgment, they dismiss all claims arising out of a covered Part B employee's employment-related exposure to beryllium or radiation that are included in the tort suit on or before the last permissible date described in paragraph (c) of this section.

(c) The last permissible date is the later of:

(1) April 30, 2003; or

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, ''the date the claimant or claimants first became aware'' will be deemed to be the date they received either a reconstructed dose from HHS, or a diagnosis of a covered beryllium illness, as applicable.

§ 30.619 Do all the parties to this type of tort suit have to take these actions?

The type of tort suits described in § 30.615 may be filed by more than one individual, each with a different cause of action. For example, a tort suit may be filed against a beryllium vendor by both a covered Part B employee and his or her spouse, with the covered Part B employee claiming for chronic beryllium disease and the spouse claiming for loss of consortium due to the covered Part B employee's exposure to beryllium. However, since the spouse of a living covered Part B employee could not be an eligible surviving beneficiary under Part B of EEOICPA, the spouse would not have to comply with the termination requirements of §§ 30.616 through 30.618. A similar result would occur if a tort suit were filed by both the spouse of a deceased covered Part B employee and other family members (such as children of the deceased covered part B employee). In this case, the spouse would be the only eligible surviving beneficiary of the deceased covered Part B employee under Part B of the EEOICPA because the other family members could not be eligible for benefits while he or she was alive. As a result, the spouse would be the only party to the tort suit who would have to comply with the termination requirements of §§ 30.616 through 30.618.

§ 30.620 How will OWCP ascertain whether a claimant filed this type of tort suit and if he or she has been disqualified from receiving any benefits under Part B of EEOICPA?

Prior to authorizing payment on a claim under Part B of EEOICPA, OWCP will require each claimant to execute and provide an affidavit stating if he or she filed a tort suit (other than an administrative or judicial proceeding for workers' compensation) against either a beryllium vendor or an atomic weapons employer that included a claim arising out of a covered Part B employee's employment-related exposure to beryllium or radiation, and if so, the current status of such tort suit. OWCP may also require the submission of any supporting evidence necessary to confirm the particulars of any affidavit provided under this section.

COORDINATION OF PART E BENEFITS WITH STATE WORKERS' COMPENSATION BENEFITS

§ 30.625 What does "coordination of benefits" mean under Part E of EEOICPA?

In general, ''coordination of benefits'' under Part E of the Act occurs when compensation to be received under Part E is reduced by OWCP, pursuant to section 7385s–11 of EEOICPA, to reflect certain benefits the beneficiary

receives under a state workers' compensation program for the same covered illness.

§ 30.626 How will OWCP coordinate compensation payable under Part E of EEOICPA with benefits from state workers' compensation programs?

(a) OWCP will reduce the compensation payable under Part E by the amount of benefits the claimant receives from a state workers' compensation program by reason of the same covered illness, after deducting the reasonable costs to the claimant of obtaining those benefits.

(b) To determine the amount of any reduction of EEOICPA compensation, OWCP shall require the covered Part E employee or each eligible surviving beneficiary filing a claim under Part E to execute and provide affidavits reporting the amount of any benefit received pursuant to a claim filed in a state workers' compensation program for the same covered illness.

(c) If a covered Part E employee or a survivor of such employee receives benefits through a state workers' compensation program pursuant to a claim for the same covered illness, OWCP shall reduce a portion of the dollar amount of such state workers' benefit from the compensation payable under Part E. OWCP will calculate the net amount of the state workers' compensation benefit amount to be subtracted from the compensation payment under Part E in the following manner:

(1) OWCP will first determine the dollar value of the benefits received by that individual from a state workers' compensation program by including all benefits, other than medical and vocational rehabilitation benefits, received for the same covered illness or injury sustained as a consequence of a covered illness.

(2) OWCP will then make certain deductions from the above dollar benefit received under a state workers' compensation program to arrive at the dollar amount that will be subtracted from any compensation payable under Part E of EEOICPA.

(i) Allowable deductions consist of reasonable costs in obtaining state workers' compensation benefits incurred by that individual, including but not limited to attorney's fees OWCP deems reasonable and itemized costs of suit (out-of-pocket expenditures not part of the normal overhead of a law firm's operation like filing, travel expenses, witness fees, and court reporter costs for transcripts), provided that adequate supporting documentation is submitted to OWCP for its consideration.

(ii) The EEOICPA benefits that will be reduced will consist of any unpaid monetary payments payable in the future and medical benefits payable in the future. In those cases where it has not yet paid EEOICPA benefits under Part E, OWCP will reduce such benefits on a dollar-for-dollar basis, beginning with the current monetary payments first. If the amount to be subtracted exceeds the monetary payments currently payable, OWCP will reduce ongoing EEOICPA medical benefits payable in the future by the amount of any remaining surplus. This means that OWCP will apply the amount it would otherwise pay to reimburse the covered Part E employee for any ongoing EEOICPA medical treatment to the remaining surplus until it is absorbed (or until further monetary benefits become payable that are sufficient to absorb the surplus).

(3) The above coordination of benefits will not occur if the beneficiary under a state workers' compensation program receives state workers' compensation benefits for both a covered and a non-covered illness arising out of and in the course of the same work-related incident.

§ 30.627 Under what circumstances will OWCP waive the statutory requirement to coordinate these benefits?

A waiver to the requirement to coordinate Part E benefits with benefits paid under a state workers' compensation program may be granted if OWCP determines that the administrative costs and burdens of coordinating benefits in a particular case or class of cases justifies the waiver. This decision is exclusively within the discretion of OWCP.

Subpart H—Information for Medical Providers

MEDICAL RECORDS AND BILLS

§ 30.700 What kinds of medical records must providers keep?

Federal Government medical officers, private physicians and hospitals are required to keep records of all cases treated by them under EEOICPA so they can supply OWCP with a history of the claimed occupational illness or covered illness, a description of the nature and extent of the claimed occupational illness or covered illness, the results of any diagnostic studies performed, and the nature of the treatment rendered. This requirement terminates after a provider has supplied OWCP with the above-noted information, and otherwise terminates ten years after the record was created.

§ 30.701 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 30.700. The physician or provider shall itemize the charges on Form OWCP–1500 or CMS–1500 (for professional charges), Form OWCP–04 or UB–04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies), or other form as warranted, and submit the form or bill promptly for processing.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC) number, or the Revenue Center Code (RCC), with a brief narrative description. Where no code is applicable, a detailed description of services performed should be provided.

(c) For professional charges billed on Form OWCP–1500 or CMS–1500, the provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the ''International Classification of Disease, 9th Edition, Clinical Modification'' (ICD–9–CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the occupational illness is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for medical and surgical treatment or supplies promptly on Form OWCP–04 or UB–04. The provider shall identify each outpatient radiology service, outpatient pathology service and physical therapy service performed, using HCPCS/CPT codes with a brief narrative description. The charge for each individual service, or the total charge for all identical services, should also appear on the form.

(ii) Other outpatient hospital services for which HCPCS/CPT codes exist shall also be coded individually using the coding scheme noted in this section. Services for which there are no HCPCS/CPT codes available can be presented using the RCCs described in the ''National Uniform Billing Data Elements Specifications,'' current edition. The provider shall also furnish the diagnostic code using the ICD–9–CM. If the outpatient hospital services include surgical and/or invasive procedures, the provider shall code each procedure using the proper HCPCS/CPT codes and furnishing the corresponding diagnostic codes using the ICD–9–CM.

(2) Pharmacies shall itemize charges for prescription medications, appliances, or supplies on electronic or paper-based bills and submit them promptly for processing. Bills for prescription medications must include all required data elements, including the NDC number assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly for processing.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which payment is sought was performed as described and was necessary. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart

concerning the rendering of treatment and/or the process for seeking payment for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: Be itemized on Form OWCP–1500 or CMS–1500 (for physicians), Form OWCP–04 or UB–04 (for hospitals), or an electronic or paper-based bill that includes required data elements (for pharmacies); contain the signature or signature stamp of the provider; and identify the procedures using HCPCS/CPT codes, RCCs, or NDC numbers. Otherwise, the bill may be returned to the provider for correction and resubmission. The decision of OWCP whether to pay a provider's bill is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.702 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or other services, supplies or appliances provided by a professional due to an occupational illness or a covered illness, he or she must submit a request for reimbursement on Form OWCP–915, together with an itemized bill on Form OWCP–1500 or CMS–1500 prepared by the provider and a medical report as provided in § 30.700, for consideration.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD–9–CM code and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service.

(2) The reimbursement request must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back) or a copy of the employee's credit card receipt.

(b) If a hospital, pharmacy or nursing home provided services for which the employee paid, the employee must also use Form OWCP–915 to request reimbursement and should submit the request in accordance with the provisions of § 30.701(a). Any such request for reimbursement must be accompanied by evidence, as described in paragraph (a)(2) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) The requirements of paragraphs (a) and (b) of this section may be waived if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) Copies of bills submitted for reimbursement will not be accepted unless they bear the original signature of the provider and evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by OWCP, as set forth in § 30.705. The decision of OWCP whether to reimburse an employee for out-of-pocket medical expenses, and the amount of any reimbursement, is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by OWCP's schedule. If this happens, the employee will be advised of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the

date of a subsequent reconsideration decision which continues to disallow all or a portion of the disputed amount, OWCP will initiate exclusion procedures as provided by § 30.715.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the allowed charge, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

§ 30.703 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

MEDICAL FEE SCHEDULE

§ 30.705 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services furnished by physicians, hospitals and other providers for occupational illnesses or covered illnesses shall not exceed a maximum allowable charge for such service as determined by OWCP, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 30.706 How are the maximum fees defined?

For professional medical services, OWCP shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs; and a monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

§ 30.707 How are payments for particular services calculated?

Payment for a procedure identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the relative values for that procedure by the geographic indices for services in that area and by the dollar amount assigned to one unit in that category of service.

(a) The ''locality'' which serves as a basis for the determination of average cost is defined by the Bureau of Census Metropolitan Statistical Areas. OWCP shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by the Centers for Medicare and Medicaid Services (CMS).

(b) OWCP shall assign the relative value units (RVUs) published by CMS to all services for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, OWCP may develop and assign any RVUs considered appropriate. The geographic adjustment factor shall be that designated by Geographic Practice Cost Indices for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for each category of service, and in doing so may adapt CMS conversion factors as appropriate using OWCP's processing experience and internal data.

(c) For example, if the unit values for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the dollar value assigned to one unit in that category of service (surgery) is $61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding geographical indices for the locality times the conversion factor. If the geographic indices for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$
$[2.45 + 3.44 + .56] \times \$61.20$
$6.45 \times \$61.20 = \$394.74$

§ 30.708 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, OWCP may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for directed medical examinations, and for other specially authorized services.

§ 30.709 How are payments for medicinal drugs determined?

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee.

(a) All prescription medications identified by NDC number will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. OWCP will establish the dispensing fee.

(b) The NDC numbers, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

§ 30.710 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Prospective Payment System (PPS) devised by CMS (42 CFR parts 412, 413, 424, 485, and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All hospital discharges will be classified according to the DRGs prescribed by CMS in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by CMS to determine the specific rate for a hospital discharge under their PPS. OWCP may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS's PPS on consideration of detailed medical reports and other evidence.

(4) OWCP shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

(b) OWCP shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when OWCP deems it necessary or appropriate.

§ 30.711 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and

other evidence. Where no code is supplied, OWCP may determine the code based on the narrative description of the procedure on the billing form and in associated medical reports. OWCP will pay no more than the maximum allowable fee for that procedure.

(b) If the charge submitted for a service supplied to an employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge. The decision of OWCP to pay less than the charged amount is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.712 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by OWCP may, within 30 days, request reconsideration of the fee determination.

(1) Any such request will be considered by the district office with jurisdiction over the employee's claim. The request must be accompanied by documentary evidence that the procedure performed was either incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board certification in a specialty is not sufficient evidence of unusual qualifications to justify a charge in excess of the maximum allowable amount set by OWCP. These are the only three circumstances that will justify reevaluation of the paid amount.

(2) A list of district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or on the Internet at *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*. Within 30 days of receiving the request for reconsideration, the district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the district office issues a decision that continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

§ 30.713 If OWCP reduces a fee, may a provider bill the employee for the balance?

A provider whose fee for service is partially paid by OWCP as a result of the application of its fee schedule or other tests for reasonableness in accordance with this part shall not request payment from the employee for the unpaid amount of the provider's bill.

(a) Where a provider's fee for a particular service or procedure is lower to the general public than as provided by the schedule of maximum allowable charges, the provider shall bill at the lower rate. A fee for a particular service or procedure which is higher than the provider's fee to the general public for that same service or procedure will be considered a charge ''substantially in excess of such provider's customary charges'' for the purposes of § 30.715(d).

(b) A provider whose fee for service is partially paid by OWCP as the result of the application of the schedule of maximum allowable charges and who collects or attempts to collect from the employee, either directly or through a collection agent, any amount in excess of the charge allowed by OWCP, and who does not cease such action or make appropriate refund to the employee within 60 days of the date of the decision of OWCP, shall be subject to

the exclusion procedures provided by § 30.715(h).

EXCLUSION OF PROVIDERS

§ 30.715 What are the grounds for excluding a provider from payment under this part?

A physician, hospital, or provider of medical services or supplies shall be excluded from payment under this part if such physician, hospital or provider has:

(a) Been convicted under any criminal statute of fraudulent activities in connection with any federal or state program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;

(b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any federal or state program referred to in paragraph (a) of this section;

(c) Knowingly made, or caused to be made, any false statement or misrepresentation of a material fact in connection with a determination of the right to reimbursement under this part, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a 12-month period under this subpart containing charges which OWCP finds to be substantially in excess of such provider's customary charges, unless OWCP finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by § 30.700 of this part;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards; or

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP.

§ 30.716 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

(a) OWCP shall automatically exclude a physician, hospital, or provider of medical services or supplies who:

(1) Has been convicted of a crime described in § 30.715(a); or

(2) Has been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any federal or state program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies.

(b) The exclusion applies to participating in the program and to seeking payment under this part for services performed after the date of the entry of the judgment of conviction or order of exclusion, suspension or resignation, as the case may be, by the court or agency concerned. Proof of the conviction, exclusion, suspension or resignation may consist of a copy thereof authenticated by the seal of the court or agency concerned.

§ 30.717 When are OWCP's exclusion procedures initiated?

Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has engaged in activities enumerated in paragraphs (c) through (h) of § 30.715, the Regional Director, after completion of inquiries he or she deems appropriate, may initiate procedures to exclude the provider from participation in the EEOICPA program. For the purposes of these procedures, ''Regional Director'' may include any officer designated to act on his or her behalf.

§ 30.718 How is a provider notified of OWCP's intent to exclude him or her?

The Regional Director shall initiate the exclusion process by sending the provider a letter, by certified mail and

with return receipt requested, which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which the Regional Director has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from participation in the EEOICPA program without admitting or denying the allegations presented in the letter; or

(2) Request that the decision on exclusion be based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the Regional Director, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to answer (as described in § 30.719) the letter of intent within 30 calendar days of receipt, the Regional Director may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The name and address of the OWCP representative who shall be responsible for receiving the answer from the provider.

§ 30.719 What requirements must the provider's reply and OWCP's decision meet?

(a) The provider's answer shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to answer the letter of intent within 30 calendar days of receipt, the Regional Director may deem the allegations made therein to be true and may order exclusion of the provider.

(c) By arrangement with the OWCP representative, the provider may inspect or request copies of information in the record at any time prior to the Regional Director's decision.

(d) The Regional Director shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested. The decision shall advise the provider of his or her right to request, within 30 days of the date of the adverse decision, a formal hearing before an administrative law judge under the procedures set forth in § 30.720. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

§ 30.720 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the OWCP representative named pursuant to § 30.718(f) and shall contain:

(a) A concise notice of the issues on which the provider desires to give evidence at the hearing;

(b) Any request for a more definite statement by OWCP;

(c) Any request for the presentation of oral argument or evidence; and

(d) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or federal, state or local regulatory body.

§ 30.721 How are hearings assigned and scheduled?

(a) If the designated OWCP representative receives a timely request for hearing, the OWCP representative shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and Hearing Schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and Hearing Schedule shall include:

(1) A ruling on each item raised in the request for hearing;

(2) A schedule for the prompt disposition of all preliminary matters, including requests for more definite statements and for the certification of questions to advisory bodies; and

(3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The purpose of the designation of issues is to provide for an effective hearing process. The provider is entitled to be heard on any matter placed in issue by his or her response to the Notice of Intent to Exclude, and may designate ''all issues'' for purposes of hearing. However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses or request the certification of questions for an advisory opinion.

§ 30.722 How are subpoenas or advisory opinions obtained?

(a) In exclusion proceedings involving medical services provided under Part B of the Act only, the provider may apply to the administrative law judge for the issuance of subpoenas upon a showing of good cause therefore.

(b) A certification of a request for an advisory opinion concerning professional medical standards, medical ethics or medical regulation to a competent recognized or professional organization or federal, state or local regulatory agency may be made:

(1) As to an issue properly designated by the provider, in the sound discretion of the administrative law judge, provided that the request will not unduly delay the proceedings;

(2) By OWCP on its own motion either before or after the institution of proceedings, and the results thereof shall be made available to the provider at the time that proceedings are instituted or, if after the proceedings are instituted, within a reasonable time after receipt. The opinion, if rendered by the organization or agency, is advisory only and not binding on the administrative law judge.

§ 30.723 How will the administrative law judge conduct the hearing and issue the recommended decision?

(a) To the extent appropriate, proceedings before the administrative law judge shall be governed by 29 CFR part 18.

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the Notice and Response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

(c) All hearings shall be recorded and the original of the complete transcript shall become a permanent part of the official record of the proceedings.

(d) In conjunction with the hearing, the administrative law judge may:

(1) Administer oaths; and

(2) Examine witnesses.

(e) At the conclusion of the hearing, the administrative law judge shall issue a written decision and cause it to be served on all parties to the proceeding, their representatives and OWCP.

§ 30.724 How can a party request review by OWCP of the administrative law judge's recommended decision?

(a) Any party adversely affected or aggrieved by the decision of the administrative law judge may file a petition for discretionary review with the Director for Energy Employees Occupational Illness Compensation within 30 days after issuance of such decision. The administrative law judge's decision, however, shall be effective on the date issued and shall not be stayed except upon order of the Director.

(b) Review by the Director for Energy Employees Occupational Illness Compensation shall not be a matter of right

but of the sound discretion of the Director.

(c) Petitions for discretionary review shall be filed only upon one or more of the following grounds:

(1) A finding or conclusion of material fact is not supported by substantial evidence;

(2) A necessary legal conclusion is erroneous;

(3) The decision is contrary to law or to the duly promulgated rules or decisions of OWCP;

(4) A substantial question of law, policy, or discretion is involved; or

(5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by any party shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) A statement in opposition to the petition for discretionary review may be filed, but such filing shall in no way delay action on the petition.

(f) If a petition is granted, review shall be limited to the questions raised by the petition.

(g) A petition not granted within 20 days after receipt of the petition is deemed denied.

§ 30.725 What are the effects of non-automatic exclusion?

(a) OWCP shall give notice of the exclusion of a physician, hospital or provider of medical services or supplies to:

(1) All OWCP district offices;

(2) CMS; and

(3) All employees who are known to have had treatment, services or supplies from the excluded provider within the six-month period immediately preceding the order of exclusion.

(b) Notwithstanding any exclusion of a physician, hospital, or provider of medical services or supplies under this subpart, OWCP shall not refuse an employee reimbursement for any otherwise reimbursable medical treatment, service or supply if:

(1) Such treatment, service or supply was rendered in an emergency by an excluded physician; or

(2) The employee could not reasonably have been expected to know of such exclusion.

(c) An employee who is notified that his or her attending physician has been excluded shall have a new right to select a qualified physician.

§ 30.726 How can an excluded provider be reinstated?

(a) If a physician, hospital, or provider of medical services or supplies has been automatically excluded pursuant to § 30.716, the provider excluded will automatically be reinstated upon notice to OWCP that the conviction or exclusion which formed the basis of the automatic exclusion has been reversed or withdrawn. However, an automatic reinstatement shall not preclude OWCP from instituting exclusion proceedings based upon the underlying facts of the matter.

(b) A physician, hospital, or provider of medical services or supplies excluded from participation as a result of an order issued pursuant to this subpart may apply for reinstatement one year after the entry of the order of exclusion, unless the order expressly provides for a shorter period. An application for reinstatement shall be addressed to the Director for Energy Employees Occupational Illness Compensation, and shall contain a concise statement of the basis for the application. The application should be accompanied by supporting documents and affidavits.

(c) A request for reinstatement may be accompanied by a request for oral argument. Oral argument will be allowed only in unusual circumstances where it will materially aid the decision process.

(d) The Director for Energy Employees Occupational Illness Compensation shall order reinstatement only in instances where such reinstatement is clearly consistent with the goal of this subpart to protect the EEOICPA program against fraud and abuse. To satisfy this requirement the provider must provide reasonable assurances

that the basis for the exclusion will not be repeated.

Subpart I—Wage-Loss Determinations Under Part E of EEOICPA

General Provisions

§ 30.800 What types of wage-loss are compensable under Part E of EEOICPA?

Years of wage-loss occurring prior to normal retirement age that are the result of a covered illness contracted by a covered Part E employee through work-related exposure to a toxic substance at a Department of Energy facility or a RECA section 5 facility, as appropriate, may be compensable under Part E of the Act. Whether years of wage-loss are compensable depends on determinations with respect to:

(a) The average annual wage of the employee as determined by OWCP in accordance with § 30.810;

(b) The percentage of his or her average annual wage that the employee was able to earn during the calendar year(s) in question as determined by OWCP in accordance with § 30.811; and

(c) Whether the employee's inability to earn at least as much as his or her average annual wage was due to a covered illness as defined in § 30.5(r).

§ 30.801 What special definitions does OWCP use in connection with Part E wage-loss determinations?

For the purposes of paying compensation based on wage-loss under Part E of the Act, OWCP will apply the following definitions:

(a) *Average annual wage* means four times the average quarterly wages of a covered Part E employee for the 12 quarters preceding the quarter during which he or she first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility, excluding any quarters during which the employee was unemployed. Because being ''retired'' is not equivalent to being ''unemployed,'' quarters during which an employee had no wages because he or she was retired will not be excluded from this calculation.

(b) *Normal retirement age* means the age at which a covered Part E employee first became eligible for unreduced retirement benefits under the Old-Age, Survivors and Disability Insurance (OASDI) provisions of the Social Security Act. In general, persons born during or before 1937 are eligible for unreduced OASDI retirement benefits at age 65, and that age increases in monthly increments until it reaches 67, which is the age at which persons born during or after 1960 become eligible for unreduced OASDI retirement benefits.

(c) *Quarter* means the three-month period January through March, April through June, July through September, or October through December.

(d) *Quarter during which the employee was unemployed* means any quarter during which the covered Part E employee had $700 (in constant 2005 dollars) or less in wages unless the quarter is one during which the employee was retired.

(e) *Year of wage-loss* means a calendar year during which the covered Part E employee's earnings were less than his or her average annual wage, after such earnings have been adjusted using the Consumer Price Index for All Urban Consumers (CPI–U), as produced by the Bureau of Labor Statistics, to reflect their value in the year during which the employee first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility.

Evidence of Wage-Loss

§ 30.805 What evidence does OWCP use to determine a covered Part E employee's average annual wage and whether he or she experienced compensable wage-loss under Part E of EEOICPA?

(a) OWCP may rely on quarterly wages information reported to the Social Security Administration to establish a covered Part E employee's presumed average annual wage (see § 30.810) and the duration and extent of any years of wage-loss that are compensable under Part E of the Act (see § 30.811). OWCP may also rely on other probative evidence of a covered Part E employee's wages, and may ask the claimant for additional evidence necessary to make this determination, if necessary. For the purposes of making

these two types of determinations, OWCP will consider all monetary payments that the covered Part E employee received in a quarter from employment or services, except for monetary payments that were not taxable as income during that quarter under the Internal Revenue Code, to be ''wages.''

(b) OWCP also requires the submission of rationalized medical evidence of sufficient probative value to establish that the period of wage-loss at issue is causally related to the covered Part E employee's covered illness.

§ 30.806 May a claimant submit factual evidence in support of a different determination of average annual wage and/or wage-loss than that found by OWCP?

A claimant who disagrees with the evidence OWCP has obtained under § 30.805(a) and alleges a different average annual wage for the covered Part E employee, or that there was a greater duration or extent of wage-loss, may submit records that were produced in the ordinary course of business due to the employee's employment to rebut that evidence, to the extent that such records are determined to be authentic by OWCP by a preponderance of the evidence. The average annual wage and/or wage-loss of the covered Part E employee will then be determined by OWCP in the exercise of its discretion.

DETERMINATIONS OF AVERAGE ANNUAL WAGE AND PERCENTAGES OF LOSS

§ 30.810 How will OWCP calculate the average annual wage of a covered Part E employee?

To calculate the average annual wage of a covered Part E employee as defined in § 30.801(a), OWCP will:

(a) Aggregate the wages for the twelve quarters that preceded the quarter during which the covered Part E employee first experienced wage-loss due to exposure to a toxic substance at a DOE facility or a RECA section 5 facility, excluding any quarter during which the employee was unemployed;

(b) Add any additional wages earned by the employee during those same quarters as evidenced by records described in §§ 30.805(a) and 30.806;

(c) Divide the sum of paragraphs (a) and (b) of this section by 12 less the number of quarters during which the employee was unemployed; and

(d) Multiply this figure by four to calculate the covered Part E employee's average annual wage.

§ 30.811 How will OWCP calculate the duration and extent of a covered Part E employee's initial period of compensable wage-loss?

(a) To determine the initial calendar years of wage-loss, OWCP will use the evidence it receives under §§ 30.805 and 30.806 to determine the quarter in which a covered Part E employee first sustained wage-loss due to exposure to a toxic substance while engaged in employment at a DOE facility or a RECA section 5 facility, as appropriate.

(b) OWCP will then compare the calendar-year wages for that employee, as adjusted, with the average annual wage determined under § 30.810 for each calendar year beginning with the calendar year that includes the quarter in which the wage-loss commenced, and concluding with the last calendar year of wage-loss prior to the submission of the claim or the calendar year in which the employee reached normal retirement age (as defined in § 30.801(b)), whichever occurred first.

(c) OWCP will then aggregate separately the number of calendar years of wage-loss in which the employee's wages, as adjusted, did not exceed 50 percent of the average annual wage determined under § 30.810, and the number of calendar years of wage-loss in which the employee's wages, as adjusted, exceeded 50 percent of such average annual wage, but did not exceed 75 percent of such average annual wage.

(d) For each calendar year of wage-loss determined under paragraph (c) of this section during which the employee's wages did not exceed 50 percent of his or her average annual wage, OWCP will pay the employee $15,000 as compensation for wage-loss. For each calendar year of wage-loss determined under paragraph (c) of this section during which the employee's calendar-year wages exceeded 50 percent of his or her average annual wage but did not exceed 75 percent of such average annual wage, OWCP will pay the employee $10,000 as compensation for wage-loss.

§ 30.812 May a covered Part E employee claim for subsequent periods of compensable wage-loss?

A covered Part E employee previously awarded compensation for wage-loss under § 30.811 may file for additional compensation for wage-loss suffered by the employee during periods subsequent to a period for which a wage-loss claim for the employee has already been adjudicated by OWCP. However, no compensation for wage-loss shall be awarded for any period following the year during which the covered Part E employee attained normal retirement age for purposes of the Social Security Act as described in § 30.801(b).

SPECIAL RULES FOR CERTAIN SURVIVOR CLAIMS UNDER PART E OF EEOICPA

§ 30.815 Are there special rules that OWCP will use to determine the extent of a deceased covered Part E employee's compensable wage-loss?

(a) For purposes of adjudicating a claim of a survivor of a deceased covered Part E employee only, OWCP will presume that such employee experienced wage-loss for each calendar year subsequent to the calendar year of his or her death through and including the calendar year in which the employee would have reached normal retirement age under the Social Security Act. During these particular calendar years, OWCP will also presume that the deceased covered Part E employee's subsequent calendar-year wages did not exceed 50 percent of his or her average annual wage as determined under § 30.810.

(b) Except as provided in paragraph (a) of this section, OWCP will calculate the wage-loss of a deceased covered Part E employee in conformance with the provisions of §§ 30.800 through 30.811.

(c) If OWCP determines that a deceased covered Part E employee had an aggregate of not less than ten calendar years of adjusted earnings that did not exceed 50 percent of his or her average annual earnings, it will pay the eligible surviving beneficiary(s) additional compensation (the basic survivor award payable under section 7385s–3(a)(1) is $125,000) in the amount of $25,000 pursuant to section 7385s–3(a)(2) of the Act. In the alternative, if OWCP determines that the aggregate number of such years is not less than 20 years, it will pay the eligible surviving beneficiary(s) additional compensation in the amount of $50,000 pursuant to section 7385s–3(a)(3).

Subpart J—Impairment Benefits Under Part E of EEOICPA

GENERAL PROVISIONS

§ 30.900 Who can receive impairment benefits under Part E?

In order to receive impairment benefits under Part E, the employee must show that:

(a) He or she is a covered Part E employee who has been determined to have contracted a covered illness through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate, pursuant to either §§ 30.210 through 30.215 or §§ 30.230 through 30.232 of these regulations; and

(b) He or she has been determined to have an impairment, pursuant to the regulations set out in this subpart, that is the result of the covered illness referred to in paragraph (a) of this section.

§ 30.901 How does OWCP determine the extent of an employee's impairment that is due to a covered illness contracted through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate?

(a) OWCP will determine the amount of impairment benefits to which an employee is entitled based on one or more impairment evaluations submitted by physicians. An impairment evaluation shall contain the physician's opinion on the extent of whole person impairment of all organs and body functions of the employee that are compromised or otherwise affected by the employee's covered illness or illnesses, which shall be referred to as a ''minimum impairment rating.''

(b) The minimum impairment rating shall be determined in accordance with the current edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*). In making impairment

benefit determinations, OWCP will only consider medical reports from physicians who are certified by the relevant medical board and who satisfy any additional criteria determined by OWCP to be necessary to qualify to perform impairment evaluations under Part E, including any specific training in use of the AMA's *Guides*, specific training and experience related to particular conditions and other objective factors.

(c) OWCP will establish criteria based upon objective factors such as training and certification that must be met by physicians preparing impairment evaluations in order for an impairment evaluation to be considered in determining an impairment award. Such criteria shall be made available to claimants and the public by OWCP.

§ 30.902 How will OWCP calculate the amount of the award of impairment benefits that is payable under Part E?

OWCP will multiply the percentage points of the minimum impairment rating by $2,500 to calculate the amount of the award.

MEDICAL EVIDENCE OF IMPAIRMENT

§ 30.905 How may an impairment evaluation be obtained?

(a) Except as provided in paragraph (b) of this section, OWCP may request that an employee undergo an evaluation of his or her permanent impairment that specifies the percentage points that are the result of the employee's covered illness or illnesses. To be of any probative value, such evaluation must be performed by a physician who meets the criteria OWCP has identified for physicians performing impairment evaluations for the pertinent covered illness or illnesses in accordance with the AMA's *Guides*.

(b) In lieu of submitting an evaluation requested by OWCP under paragraph (a) of this section, an employee may obtain an impairment evaluation at his own initiative and submit it to OWCP for consideration. Such an evaluation will be deemed to have sufficient probative value to be considered in the adjudication of impairment benefits by OWCP only if:

(1) The evaluation was performed by a physician who meets the criteria identified by OWCP for the covered illness or illnesses in question;

(2) The evaluation was performed no more than one year before the date that it was received by OWCP; and

(3) The evaluation conforms to all applicable requirements set out in this part.

§ 30.906 Who will pay for an impairment evaluation?

(a) OWCP will pay for one impairment evaluation obtained by an employee if it meets the criteria set out in § 30.905(b), unless it was performed by a physician prior to the date that the claim for Part E benefits is filed, or obtained for a claim in which OWCP finds that the employee did not contract a covered illness. At its discretion, OWCP may direct that the employee undergo additional evaluations. OWCP will pay for any such additional evaluations and will reimburse the employee for any reasonable and necessary costs incident to the evaluations, as described in §§ 30.404 and 30.412 of this part.

(b) Except for one impairment evaluation obtained pursuant to § 30.905(b) and meeting the criteria set out in § 30.905(b)(1), (2) and (3), the employee must pay for any impairment evaluations not directed by OWCP.

§ 30.907 Can an impairment evaluation obtained by OWCP be challenged prior to issuance of the recommended decision?

(a) An employee may submit arguments challenging an impairment evaluation, and/or additional medical evidence of impairment, before the district office issues a recommended decision on his or her claim. However, the district office will not consider an additional impairment evaluation, even if it differs from the impairment evaluation obtained under §§ 30.905 or 30.906, if it does not meet the criteria listed in § 30.905(b)(1), (2) and (3).

(b) If the district office obtains an additional impairment evaluation that differs from the impairment evaluation obtained under §§ 30.905 or 30.906, the district office will base its recommended determinations regarding

impairment upon the evidence it considers to have the greatest probative value, after evaluating all relevant evidence of impairment in the record, including evidence from directed impairment evaluations and referee impairment evaluations, if any, that it deems necessary pursuant to §§ 30.410 and 30.411 of this part.

§ 30.908 How will the FAB evaluate new medical evidence submitted to challenge the impairment determination in the recommended decision?

(a) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will not consider the additional impairment evaluation if it does not meet the criteria listed in § 30.905(b)(1), (2) and (3).

(b) The employee shall bear the burden of proving that the additional impairment evaluation submitted is more probative than the evaluation relied upon by the district office to determine the employee's recommended minimum impairment rating.

(c) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will review all relevant evidence of impairment in the record, and will base its determinations regarding impairment upon the evidence it considers to be most probative. The FAB will determine the minimum impairment rating after it has evaluated all relevant evidence and argument in the record.

RATABLE IMPAIRMENTS

§ 30.910 Will an impairment that cannot be assigned a numerical percentage using the AMA's Guides be included in the impairment rating?

(a) An impairment of an organ or body function that cannot be assigned a numerical impairment percentage using the AMA's *Guides* will not be included in the employee's impairment rating.

(b) A mental impairment that does not originate from a documented physical dysfunction of the nervous system, and cannot be assigned a numerical percentage using the AMA's *Guides*, will not be included in the impairment rating for the employee. Mental impairments that are due to documented physical dysfunctions of the nervous system can be assigned numerical percentages using the AMA's *Guides* and will be included in the rating.

§ 30.911 Does maximum medical improvement always have to be reached for an impairment to be included in the impairment rating?

(a) An impairment that is the result of a covered illness will be included in the employee's impairment rating determined by OWCP under § 30.901 only if OWCP concludes that the impairment has reached maximum medical improvement, which means that it is well-stabilized and unlikely to improve substantially with or without medical treatment.

(b) Notwithstanding paragraph (a) of this section, if OWCP finds that an employee's covered illness is in the terminal stages, based upon probative medical evidence, an impairment that results from such covered illness will be included in the impairment rating for the employee even if it has not reached maximum medical improvement.

§ 30.912 Can a covered Part E employee receive benefits for additional impairment following an award of such benefits by OWCP?

A covered Part E employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the impairment rating that is the result of the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

SUBCHAPTERS D–E [RESERVED]

SUBCHAPTER F—COMPENSATION FOR INJURY, DISABILITY, DEATH, OR ENEMY DETENTION OF EMPLOYEES OF CONTRACTORS WITH THE UNITED STATES

PART 61—CLAIMS FOR COMPENSATION UNDER THE WAR HAZARDS COMPENSATION ACT, AS AMENDED

Subpart A—General Provisions

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61.404 Assignments; creditors.

AUTHORITY: 1950 Reorg. Plan No. 19, sec. 1, 3 CFR, 1949–1953 Comp., p. 1010, 64 Stat. 1271; 5 U.S.C. 8145, 8149; 42 U.S.C. 1704, 1706; Secretary's Order 7–87, 52 FR 48466; Employment Standards Order 78–1, 43 FR 51469.

SOURCE: 53 FR 3679, Feb. 8, 1988, unless otherwise noted.

Subpart A—General Provisions

§ 61.1 Statutory provisions

(a) The War Hazards Compensation Act, as amended (42 U.S.C. 1701 *et seq.*) provides for reimbursement of workers' compensation benefits paid under the Defense Base Act (42 U.S.C. 1651 *et seq.*), or under other workers' compensation laws as described in §61.100(a), for injury or death causally related to a war-risk hazard.

(b) If no benefits are payable under the Defense Base Act or other applicable workers' compensation law, compensation is paid to the employee or survivors for the war-risk injury or death of—

(1) Any person subject to workers' compensation coverage under the Defense Base Act;

(2) Any person engaged by the United States under a contract for his or her personal services outside the continental United States;

(3) Any person subject to workers' compensation coverage under the Nonappropriated Fund Instrumentalities Act (5 U.S.C. 8171 *et seq.*);

(4) Any person engaged for personal services outside the continental United States under a contract approved and financed by the United States under the Mutual Security Act of 1954, as amended (other than title II of chapter II unless the Secretary of Labor, upon the recommendation of the head of any department or other agency of the U.S. Government, determines a contract financed under a successor provision of

any successor Act should be covered by this subchapter), except that in cases where the United States is not a formal party to contracts approved and financed under the Mutual Security Act of 1954, as amended, the Secretary, upon the recommendation of the head of any department or agency of the United States, may waive the application of the Act; or

(5) Any person engaged for personal services outside the continental United States by an American employer providing welfare or similar services for the benefit of the Armed Forces under appropriate authorization by the Secretary of Defense.

(c) The Act also provides for payment of detention benefits to an employee specified in paragraph (a) of this section who—

(1) If found to be missing from his or her place of employment under circumstances supporting a reasonable inference that the absence is due to the belligerent action of a hostile force or person;

(2) Is known to have been taken by a hostile force or person as a prisoner or hostage; or

(3) Is not returned to his or her home or to the place of employment due to the failure of the United States or its contractor to furnish transportation.

§ 61.2 Administration of the Act and this chapter.

(a) Pursuant to 42 U.S.C. 1706, Secretary of Labor's Order 6–84, (49 FR 32473), and Employment Standards Order 78–1, (43 FR 51469), the responsibility for administration of the Act has been delegated to the Director, Office of Workers' Compensation Programs.

(b) In administering the provisions of the Act, the Director may enter into agreements or cooperative working arrangements with other agencies of the United States or of any State (including the District of Columbia, Puerto Rico, and the Virgin Islands) or political subdivisions thereof, and with other public agencies and private persons, agencies, or institutions within and outside the United States. The Director may also contract with insurance carriers for the use of their service facilities to process claims filed under the Act

§ 61.3 Purpose and scope of this part.

(a) This part 61 sets forth the rules applicable to the filing, processing, and payment of claims for reimbursement and workers' compensation benefits under the provisions of the War Hazards Compensation Act, as amended. The provisions of this part are intended to afford guidance and assistance to any person, insurance carrier, self-insured employer, or compensation fund seeking benefits under the Act, as well as to personnel within the Department of Labor who administer the Act.

(b) Subpart A describes the statutory and administrative framework within which claims under the Act are processed, contains a statement of purpose and scope, and defines terms used in the administration of the Act.

(c) Subpart B describes the procedure by which an insurance carrier, self-insured employer, or compensation fund shall file a claim for reimbursement under section 104 of the Act, and describes the procedures for processing a claim for reimbursement and transferring a case for direct payment by the Department of Labor.

(d) Subpart C contains the rules governing the filing and processing of a claim for injury, disability or death benefits under section 101(a) of the Act.

(e) Subpart D contains provisions relating to claims for detention benefits under section 101(b) of the Act.

(f) Subpart E contains miscellaneous provisions concerning disclosure of program information, approval of claims for legal services, and assignment of claim.

§ 61.4 Definitions and use of terms.

For the purpose of this part—

(a) *The Act* means the War Hazards Compensation Act, 42 U.S.C. 1701 *et seq.*, as amended.

(b) *Office* or *OWCP* means the Office of Workers' Compensation Programs, Employment Standards Administration, United States Department of Labor.

(c) *Contractor with the United States* includes any contractor, subcontractor or subordinate subcontractor.

(d) *Carrier* means any payer of benefits for which reimbursement is requested under the Act, and includes insurance carriers, self-insured employers and compensation funds.

(e) *War-risk hazard* means any hazard arising during a war in which the United States is engaged; during an armed conflict in which the United States is engaged, whether or not war has been declared; or during a war or armed conflict between military forces of any origin, occurring within any country in which a person covered by the Act is serving; from—

(1) The discharge of any missile (including liquids and gas) or the use of any weapon, explosive, or other noxious thing by a hostile force or person or in combating an attack or an imagined attack by a hostile force or person;

(2) Action of a hostile force or person, including rebellion or insurrection against the United States or any of its allies;

(3) The discharge or explosion of munitions intended for use in connection with a war or armed conflict with a hostile force or person (except with respect to employees of a manufacturer, processor, or transporter of munitions during the manufacture, processing, or transporting of munitions, or while stored on the premises of the manufacturer, processor, or transporter);

(4) The collision of vessels in convoy or the operation of vessels or aircraft without running lights or without other customary peacetime aids to navigation; or

(5) The operation of vessels or aircraft in a zone of hostilities or engaged in war activities.

(f) *Hostile force or person* means any nation, any subject of a foreign nation, or any other person serving a foreign nation—

(1) Engaged in a war against the United States or any of its allies;

(2) Engaged in armed conflict, whether or not war has been declared, against the United States or any of its allies; or

(3) Engaged in a war or armed conflict between military forces of any origin in any country in which a person covered by the Act is serving.

(g) *Allies* means any nation with which the United States is engaged in a common military effort or with which the United States has entered into a common defensive military alliance.

(h) *War activities* includes activities directly relating to military operations.

(i) *Continental United States* means the States and the District of Columbia.

(j) *Injury* means injury resulting from a war-risk hazard, as defined in this section, whether or not such injury occurred in the course of the person's employment, and includes any disease proximately resulting from a war-risk hazard.

(k) *Death* means death resulting from an injury, as defined in this section.

(l) The terms *compensation*, *physician*, and *medical*, *surgical*, *and hospital services and supplies* when used in subparts D and E are construed and applied as defined in the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*).

(m) The terms *disability*, *wages*, *child*, *grandchild*, *brother*, *sister*, *parent*, *widow*, *widower*, *student*, *adoption* or *adopted* are construed and applied as defined in the Longshore and Harbor Workers' Compensation Act, as amended (35 U.S.C. 901 *et seq.*).

Subpart B—Reimbursement of Carriers

§ 61.100 General reimbursement provisions.

(a) The Office shall reimburse any carrier that pays benefits under the Defense Base Act or other applicable workers' compensation law due to the injury, disability or death of any person specified in § 61.1(a), if the injury or death for which the benefits are paid arose from a war-risk hazard. The amount to be reimbursed includes disability and death payments, funeral and burial expenses, medical expenses, and the reasonable and necessary claims expense incurred in processing the request.

(b) The Office shall not provide reimbursement in any case in which an additional premium for war-risk hazard was charged, or in which the carrier

has been reimbursed, paid, or compensated for the loss for which reimbursement is requested.

(c) Reimbursement under this section with respect to benefits shall be limited to the amounts which will discharge the liability of the carrier under the applicable workers' compensation law.

§ 61.101 Filing a request for reimbursement.

(a) A carrier or employer may file a request for reimbursement. The request shall be submitted to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117;

(b) Each request for reimbursement shall include documentation itemizing the payments for which reimbursement is claimed. The documentation shall be sufficient to establish the purpose of the payment, the name of the payee, the date(s) for which payment was made, and the amount of the payment. Copies of any medical reports and bills related to medical examination or treatment for which reimbursement is claimed shall also be submitted. If the carrier cannot provide copies of the payment drafts or receipts, the Office may accept a certified listing of payments which includes payee name, description of services rendered, date of services rendered, amount paid, date paid check or draft number, and signature of certifier.

(c) When filing an initial request for reimbursement under the Act, the carrier shall submit copies of all available documents related to the workers' compensation case, including—

(1) Notice and claim forms;

(2) Statements of the employee or employer;

(3) Medical reports;

(4) Compensation orders; and

(5) Proof of liability (e.g., insurance policy or other documentation).

§ 61.102 Disposition of reimbursement requests.

(a) If the Office finds that insufficient or inadequate information has been submitted with the claim, the carrier shall be asked to submit further information. Failure to supply the requested information may result in disallowance of items not adequately supported as properly reimbursable.

(b) The Office shall not withhold payment of an approved part of a reimbursement request because of denial of another part of the reimbursement request.

(c) The Office shall regard awards, decisions and approved settlement agreements under the Defense Base Act or other applicable workers' compensation law, that have become final, as establishing prima facie, the right of the beneficiary to the payment awarded or provided for.

(d) The Office shall advise the carrier of the amount approved for reimbursement. If the reimbursement request has been denied in whole or in part, the Office shall provide the carrier an explanation of the action taken and the reasons for the action. A carrier within the United States may file objections with the Associate Director for Federal Employees' Compensation to the disallowance or reduction of a claim within 60 days of the Office's decision. A carrier outside the United States has six months within which to file objections with the Associate Director. The Office may consider objections filed beyond the time limits under unusual circumstances or when reasonable cause has been shown for the delay. A determination by the Office is final.

(e) In determining whether a claim is reimbursable, the Office shall hold the carrier to the same degree of care and prudence as any individual or corporation in the protection of its interests or the handling of its affairs would be expected to exercise under similar circumstances. A part or an item of a claim may be disapproved if the Office finds that the carrier—

(1) Failed to take advantage of any right accruing by assignment or subrogation (except against the United States, directly or indirectly, its employees, or members of its armed forces) due to the liability of a third party, unless the financial condition of the third party or the facts and circumstances surrounding the liability justify the failure;

(2) Failed to take reasonable measures to contest, reduce, or terminate its liability by appropriate available

procedure under workers' compensation law or otherwise; or

(3) Failed to make reasonable and adequate investigation or injury as to the right of any person to any benefit or payment; or

(4) Failed to avoid augmentation of liability by reason of delay in recognizing or discharging a compensation claimant's right to benefits.

§ 61.103 Examination of records of carrier.

Whenever it is deemed necessary, the Office may request submission of case records or may inspect the records and accounts of a carrier for the purpose of verifying any allegation, fact or payment stated in the claim. The carrier shall furnish the records and permit or authorize their inspection as requested. The right of inspection shall also relate to records and data necessary for the determination of whether any premium or other charge was made with respect to the reimbursement claimed.

§ 61.104 Reimbursement of claims expense.

(a) A carrier may claim reimbursement for reasonable and necessary claims expense incurred in connection with a case for which reimbursement is claimed under the Act. Reimbursement may be claimed for allocated and unallocated claims expense.

(b) The term ''allocated claims expense'' includes payments made for reasonable attorneys' fees, court and litigation costs, expenses of witnesses and expert testimony, examinations, autopsies and other items of expense that were reasonably incurred in determining liability under the Defense Base Act or other workers' compensation law. Allocated claims expense must be itemized and documented as described in § 61.101.

(c) The term ''unallocated claims expense'' means costs that are incurred in processing a claim, but cannot be specifically itemized or documented. A carrier may receive reimbursement of unallocated claims expense in an amount of to 15% of the sum of the reimbursable payments made under the Defense Base Act or other workers' compensation law. If this method of computing unallocated claims expense would not result in reimbursement of reasonable and necessary claims expense, the Office may, in its discretion, determine an amount that fairly represents the expenses incurred.

(d) The Office shall not consider as a claims expense any general administrative costs, general office maintenance costs, rent, insurance, taxes, or other similar general expenses. Nor shall expenses incurred in establishing or documenting entitlement to reimbursement under the Act be considered.

§ 61.105 Direct payment of benefits.

(a) The Office may pay benefits, as they accrue, directly to any entitled beneficiary in lieu of reimbursement of a carrier.

(b) The Office will not accept a case for direct payment until the right of the person or persons entitled to benefits has been established and the Office finds that the carrier would be entitled to reimbursement for continuing benefits.

(c) The Office will not accept a case for direct payment until the rate of compensation or benefit and the period of payment have become relatively fixed and known. The Office may accept a case for direct payment before this condition has been satisfied, if the Office determines that direct payment is advisable due to the circumstances in that particular case.

(d) In cases transferred to the Office for direct payment, medical care for the effects of a war-risk injury may be furnished in a manner consistent with the regulations governing the furnishing of medical care under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, *et seq.*).

(e) The transfer of a case to the Office for direct payment does not affect the hearing or adjudicatory rights of a beneficiary or carrier as established under the Defense Base Act or other applicable workers' compensation law.

(f) The Office may retransfer any case to a carrier either for the purpose of completion of adjudicatory processes or for continuation of payment of benefits.

Subpart C—Compensation for Injury, Disability or Death

§ 61.200 Entitlement to benefits.

(a) Compensation under section 101(a) of the Act is payable for injury or death due to a war-risk hazard of an employee listed in § 61.1(a), whether or not the person was engaged in the course of his or her employment at the time of the injury.

(b) Compensation under this subpart is paid under the provisions of the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*), except that the determination of beneficiaries and the computation of compensation are made in accordance with sections 6, 8, 9, and 10 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 *et seq.*).

(c) The Office may not approve a claim for compensation if any of the following conditions are met:

(1) The employee resides at or in the vicinity of the place of employment, does not live there solely due to the exigencies of the employment, and is injured outside the course of the employment.

(2) The claim is filed due to the injury or death of a prisoner of war detained or utilized by the United States.

(3) The person seeking benefits recovers or receives workers' compensation benefits from any other source for the same injury or death.

(4) The person seeking benefits is a national of a foreign country and is entitled to compensation benefits from that or any other foreign country on account of the same injury or death.

(5) The employee is convicted in a court of competent jurisdiction of any subversive act against the United States or any of its allies.

§ 61.201 Filing of notice and claim.

An employee or his or her survivors may file a claim under section 101(a) of the Act only after a determination has been made that no benefits are payable under the Defense Base Act administered by the Office's Division of Longshore and Harbor Workers' Compensation, Notice and claim may be filed on standard Longshore or Federal Employees' Compensation Act forms. The claimant shall submit notice and claim, along with any supporting documentation, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117.

§ 61.202 Time limitations for filing notice and claim.

The time limitation provisions found in 5 U.S.C. 8119 apply to the filing of claims under section 101(a) of the War Hazards Compensation Act. The Office may waive the time limitations if it finds that circumstances beyond the claimant's control prevented the filing of a timely claim.

§ 61.203 Limitations on and deductions from benefits.

(a) Compensation payable for injury, disability or death may not exceed the maximum limitations specified in section 6(b) of the Longshore and Harbor Workers' Compensation Act, as amended.

(b) In determining benefits for disability or death, the Office shall not apply the minimum limits found in sections 6(b) and 9(e) of the Longshore and Harbor Workers' Compensation Act.

(c) Compensation for death or permanent disability payable to persons who are not citizens of the United States and who are not residents of the United States or Canada is in the same amount as provided for residents, except that dependents in a foreign country are limited to the employee's spouse and children, or if there be no spouse or children, to the employee's father or mother whom the employee supported, either wholly or in part, for the period of one year immediately prior to the date of the injury. The Office may discharge its liability for all future payments of compensation to a noncitizen/nonresident by paying a limp sum representing one-half the commuted value of all future compensation as determined by the Office.

(d) If any employee or beneficiary receives or claims wages, payments in lieu of wages, or insurance benefits for disability or loss of life (other than workers' compensation benefits), and the cost of these payments is provided in whole or in part by the United

States, the Office shall credit the amount of the benefits against any payments to which the person is entitled under the Act. The Office shall apply credit only where the wages, payments, or benefits received are items for which the contractor is entitled to reimbursement from the United States, or where they are otherwise reimbursable by the United States.

(e) If an employee who is receiving workers' compensation benefits on account of a prior accident or disease sustains an injury compensable under the Act, the employee is not entitled to any benefits under the Act during the period covered by other workers' compensation benefits unless the injury from a war-risk hazard increases the employee's disability. If the war-risk injury increases the disability, compensation under the Act is payable only for the amount of the increase in disability. This provision is applicable only to disability resulting jointly from two unrelated causes, namely, (1) prior industrial accident or disease, and (2) injury from a war-risk hazard.

(f) Compensation for disability under this subchapter, with the exception of allowances for scheduled losses of members or functions of the body, may not be paid for the same period of time during which benefits for detention under this subchapter are paid or accrued.

§ 61.204 Furnishing of medical treatment.

All medical services, appliances, drugs and supplies which in the opinion of the Office are necessary for the treatment of an injury coming within the purview of section 101(a) of the Act shall be furnished to the same extent, and wherever practicable in the same manner and under the same regulations, as are prescribed for the furnishing of medical treatment under the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*).

§ 61.205 Burial expense.

(a) When the death of a person listed in §61.1(a) results from an injury caused by a war-risk hazard, the Office shall pay reasonable burial expenses up to the amount specified in section 9 of the Longshore and Harbor Workers' Compensation Act. If any part of the burial expense has been paid by any other agency of the United States, or by any person under obligation to discharge burial expenses, the amount so paid shall be deducted from the burial expense payable by the Office. Payment will be made directly (1) to the undertaker, (2) to the estate of the deceased if the estate is obligated to make payment, or (3) to any person who has paid such burial expenses and is entitled to such reimbursement.

(b) If the employee's home is within the United States and death occurs away from the employee's home or outside the United States, the Office may pay an additional sum for transporting the remains to the home.

§ 61.206 Reports by employees and dependents.

The Office may require a claimant to submit reports of facts materially affecting the claimant's entitlement to compensation under the Act. These may include reports of recurrence or termination of disability, of employment and earnings, or of a change in the marital or dependency status of a beneficiary.

Subpart D—Detention Benefits

§ 61.300 Payment of detention benefits.

(a) The Office shall pay detention benefits to any person listed in §61.1(a) who is detained by a hostile force or person, or who is not returned to his or her home or to the place of employment by reason of the failure of the United States or its contractor to furnish transportation. Benefits are payable for periods of absence on and subsequent to January 1, 1942, regardless of whether the employee was actually engaged in the course of his or her employment at the time of capture or disappearance.

(b) For the purposes of paying benefits for detention, the employee is considered as totally disabled until the time that the employee is returned to his or her home, to the place of employment, or to the jurisdiction of the United States. The Office shall credit the compensation benefits to the employee's account, to be paid to the employee for the period of the absence or

until the employee's death is in fact established or can be legally presumed to have occurred. A part of the compensation accruing to the employee may be disbursed during the period of absence to the employee's dependents.

(c) During the period of absence of any employee detained by a hostile force or person, detention benefits shall be credited to the employee's account at one hundred percent of his or her average weekly wages. The average weekly wages may not exceed the average weekly wages paid to civilian employees of the United States performing the same or most similar employment in that geographic area. If there are eligible dependents, the Office may pay to these dependents seventy percent of the credited benefits.

(d) The Office may not pay detention benefits under any of the following conditions:

(1) The employee resides at or in the vicinity of the place of employment, does not live there solely due to the exigencies of the employment, and is detained under circumstances outside the course of the employment.

(2) The person detained is a prisoner of war detained or utilized by the United States.

(3) Workers' compensation benefits from any other source or other payments from the United States are paid for the same period of absence or detention.

(4) The person seeking detention benefits is a national of a foreign country and is entitled to compensation benefits from that or any other foreign country on account of the same absence or detention.

(5) The employee has been convicted in a court of competent jurisdiction of any subversive act against the United States or any of its allies.

§ 61.301 Filing a claim for detention benefits.

(a) A claim for detention benefits shall contain the following information: Name, address, and occupation of the missing employee; name, address and relation to the employee of any dependent making claim; name and address of the employer; contract number under which employed; date, place and circumstances of capture or detention; date, place and circumstances of release (if applicable). The employer shall provide information about the circumstances of the detention and the employee's payrate at the time of capture. Dependents making claim for detention benefits may be required to submit all evidence available to them concerning the employment status of the missing person and the circumstances surrounding his or her absence.

(b) A claim filed by a dependent or by the employee upon his or her release should be sent with any supporting documentation to the U.S. Department of Labor, Office of Workers' Compensation Programs, Branch of Special Claims, P.O. Box 37117, Washington, DC 20013–7117.

§ 61.302 Time limitations for filing a claim for detention benefits.

The time limitation provisions found in the Federal Employees' Compensation Act, as amended (5 U.S.C. 8101 *et seq.*) apply to the filing of claims for detention benefits. The Office may waive the time limitations if it finds that circumstances beyond the claimant's control prevented the filing of a timely claim.

§ 61.303 Determination of detention status.

A determination that an employee has been detained by a hostile force or person may be made on the basis that the employee has disappeared under circumstances that make detention appear probable. In making the determination, the Office will consider the information and the conclusion of the Department or agency of the United States having knowledge of the circumstances surrounding the absence of the employee as prima facie evidence of the employee's status. The presumptive status of total disability of the missing person shall continue during the period of the absence, or until death is in fact established or can be legally presumed to have occurred.

§ 61.304 Limitations on and deductions from detention benefits.

(a) In determining benefits for detention, the Office shall not apply the minimum limits found in sections 6(b)

and 9(e) of the Longshore and Harbor Workers' Compensation Act.

(b) If any employee or dependent receives or claims wages, payments in lieu of wages, or insurance benefits for the period of detention, and the cost of the wages, payments or benefits is provided in whole or in part by the United States, the Office shall credit the amount of the benefits against any detention payments to which the person is entitled under the Act. The Office shall apply credit only where the wages, payments, or benefits received are items for which the contractor is entitled to reimbursement from the United States, or where they are otherwise reimbursable by the United States.

§ 61.305 Responsibilities of dependents receiving detention benefits.

A dependent having knowledge of a change of status of a missing employee shall promptly inform the Office of the change. The Office must be advised immediately by the dependent if the employee is returned home or to the place of his or her employment, or is able to be returned to the jurisdiction of the United States.

§ 61.306 Transportation of persons released from detention and return of employees.

(a) The Office may furnish the cost of transporting an employee from the point of the employee's release from detention to his or her home, the place of employment, or other place within the jurisdiction of the United States. The Office shall not pay for transportation if the employee is furnished the transportation under any agreement with his or her employer or under any other provision of law.

(b) The Office may furnish the cost of transportation under circumstances not involving detention, if the furnishing of transportation is an obligation of the United States or its contractor, and the United States or its contractor fails to return the employee to his or her home or to the place of employment.

§ 61.307 Transportation of recovered bodies of missing persons.

If an employee dies while in detention and the body is later recovered, the Office may provide the cost of transporting the body to the home of the deceased or to any place designated by the employee's next of kin, near relative, or legal representative.

Subpart E—Miscellaneous Provisions

§ 61.400 Custody of records relating to claims under the War Hazards Compensation Act.

All records, medical and other reports, statements of witnesses and other papers filed with the Office with respect to the disability, death, or detention of any person coming within the purview of the Act, are the official records of the Office and are not records of the agency, establishment, Government department, employer, or individual making or having the care or use of such records.

§ 61.401 Confidentiality of records.

Records of the Office pertaining to injury, death, or detention are confidential, and are exempt from disclosure to the public under section 552(b)(6) of title 5, U.S. Code. No official or employee of the United States who has investigated or secured statements from witnesses and others pertaining to any case within the purview of the Act, or any person having the care or use of such records, shall disclose information from or pertaining to such records to any person, except in accordance with applicable regulations (see 29 CFR part 70a).

§ 61.402 Protection, release, inspection and copying of records.

The protection, release, inspection and copying of the records shall be accomplished in accordance with the rules, guidelines and provisions contained in 29 CFR parts 70 and 70a and the annual notice of systems of records and routine uses as published in the FEDERAL REGISTER.

§ 61.403 Approval of claims for legal and other services.

(a) No claim for legal services or for any other services rendered in respect to a claim or award for compensation under the Act to or on account of any person shall be valid unless approved by the Office. Any such claim approved by the Office shall, in the manner and to the extent fixed by the Office, be paid out of the compensation payable to the claimant.

(b) The Office shall not recognize a contract for a stipulated fee or for a fee on a contingent basis. No fee for services shall be approved except upon application supported by a sufficient statement of the extent and character of the necessary work done on behalf of the claimant. Except where the claimant was advised that the representation would be rendered on a gratuitous basis, the fee approved shall be reasonably commensurate with the actual necessary work performed by the representative, and with due regard to the capacity in which the representative appeared, the amount of compensation involved, and the circumstances of the claimant.

§ 61.404 Assignments; creditors.

The right of any person to benefits under the Act is not transferable of assignable at law or in equity except to the United States, and none of the moneys paid or payable (except money paid as reimbursement for funeral expenses), or rights existing under the Act are subject to execution, levy, attachment, garnishment, or other legal process or to the operation of any bankruptcy or insolvency law.

SUBCHAPTER G—COMPENSATION FOR INJURY, DISABILITY OR DEATH OF CIVILIAN AMERICAN CITIZENS INCURRED WHILE DETAINED BY OR IN HIDING FROM THE IMPERIAL JAPANESE GOVERNMENT

PART 71—GENERAL PROVISIONS

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71.3 Deductions from benefits.
71.4 Limitation upon benefits.
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71.7 Claim filing, processing, adjudication and time limits.

AUTHORITY: Sec. 32, 39 Stat. 749, as amended, sec. 106, 56 Stat. 1033, as amended, sec. 5, 62 Stat. 1242, as amended; 5 U.S.C. 8145, 8149, 42 U.S.C. 1706, 50 U.S.C. App., 2004.

SOURCE: 16 FR 2933, Apr. 4, 1951, unless otherwise noted.

§ 71.1 General administrative provisions.

(a) Section 5(f) of the War Claims Act of 1948 (act of July 3, 1948; Pub. L. 896, 80th Cong., 62 Stat. 1240) makes provision for the payment of benefits with respect to the injury, disability or death resulting from injury of any civilian American citizen occurring while he was held by or in hiding from the Imperial Japanese Government to the same extent as if such civilian American citizen were an employee within the purview of the act of December 2, 1942 (Pub. L. 784, 77th Cong., 56 Stat. 1028, 42 U.S.C. 1701, et seq.). Under section 5(f) of the said War Claims Act of 1948, the rights of individuals to benefits payable under this subchapter shall accrue from and after December 7, 1941, subject, however, to all of the provisions of said act and the regulations in this subchapter.

(b) The regulations in part 61 of subchapter F of this chapter governing the administration of the benefits provided under titles I and II of the said act of December 2, 1942, as amended, shall, insofar as they are applicable and are not inconsistent with any of the provisions of this subchapter, govern the administration of the benefits payable under this subchapter. Provisions of such regulations relating to benefits for detention by the enemy, reimbursement to an employer or insurance carrier, and limitations on benefits in cases where workmen's compensation is payable are not applicable to the benefits provided in this subchapter nor are they within the purview of this subchapter. The provisions of sections 101(b), 104 and 105 of such act of December 2, 1942, and the various provisions of part 61 of this chapter relating to such provisions, accordingly, are not applicable to the payment of benefits under this subchapter.

(c) All rights or benefits under this subchapter which are determinable with reference to other provisions of law other than the said War Claims Act of 1948, shall be determined with reference to such provisions as they existed and were in force on January 3, 1948.

(d) As used in this subchapter:

(1) The term ''Bureau'' means the Bureau of Employees' Compensation, U.S. Department of Labor.

(2) The term ''civilian American citizen'' means any person who, being then a citizen of the United States, was captured by the Imperial Japanese Government on or after December 7, 1941, at Midway, Guam, Wake Island, the Philippine Islands, or any Territory or possession of the United States attacked or invaded by such government or while in transit to or from any such place, or who went into hiding at any such place in order to avoid capture or internment by such government; except (i) a person who at any time voluntarily gave aid to, collaborated with, or in any manner served such government, or (ii) a person who at the time of his capture or entrance into hiding was within the purview of the Federal Employees' Compensation Act of September 7, 1918, as amended and extended, or the said act of December 2, 1942, as amended, or the Missing Persons Act of March 7, 1942 (56 Stat. 143), as amended, or who was a regularly appointed, enrolled, enlisted, or

inducted member of any military or naval force.

(3) The terms ''held by the Imperial Japanese Government'' or ''captured by the Imperial Japanese Government'' mean a holding of such person as a prisoner, internee, hostage or in any other capacity.

(4) The terms ''compensation'', ''physician'' and ''medical, surgical and hospital services and supplies'' shall be construed and applied as defined in the Federal Employees' Compensation Act of September 7, 1916, as amended.

(5) The term ''benefit'' is construed as synonymous with the term ''compensation''.

(6) The terms ''disability'', ''wages'', ''child'', ''grandchild'', ''brother'', ''sister'', ''parent'', ''widow'', ''widower'', ''adoption'' or ''adopted'' shall be construed and applied as defined in the Longshoremen's and Harbor Workers' Compensation Act, as amended.

§ 71.2 Computation of benefits.

(a) For the purpose of determining the benefits under this subchapter, the average weekly wage of any such civilian American citizen, whether employed, self-employed, or not employed, shall be deemed to have been $37.50. The provisions of this subchapter are applicable and benefits are payable whether or not such civilian American citizen was employed. Monthly compensation in cases involving partial disability shall be determined by the percentage which the degree of partial disability bears to total disability, and shall not be determined with respect to the extent of loss of wage-earning capacity.

(b) Notwithstanding any of the provisions of part 61 of this chapter, total maximum aggregate compensation for disability payable under this subchapter is limited to $7,500 in case of injury and $7,500 in case of death, such sum being exclusive of medical costs and funeral and burial expenses.

§ 71.3 Deductions from benefits.

If a civilian American citizen or his dependents receives or has received from the United States any payments on account of the same injury or death, or from his employer in the form of wages or payments in lieu of wages, or in any form of support or compensation (including workmen's compensation) in respect to the same objects, the benefits under this subchapter shall be diminished in the case of an injured person by the amount of payments such injured person received on account of the same injury or disability, or in the case of dependents, by the amount of payments such dependents of the deceased civilian American citizen received on account of the same death, as the case may be.

§ 71.4 Limitation upon benefits.

No person, except a widow or a child, shall be entitled to benefits under this subchapter for disability with respect to himself and to death benefits on account of the death of another.

§ 71.5 Payment of benefits.

(a) Benefits under this subchapter payable for disability or death shall be paid only to the person entitled thereto, or to his legal or natural guardian if he has one, and shall not upon death of the person so entitled survive for the benefit of his estate or any other person.

(b) The benefit of a minor or an incompetent person who has no natural or legal guardian may, in the discretion of the Bureau be paid in whole or in such part as the Bureau may determine, for and on behalf of such minor or incompetent directly to the person or institution caring for, supporting or having custody of such minor or incompetent.

(c) In any case in which benefits are payable under this subchapter to any person who is prevented from accepting such benefits by the rules, regulations or customs of the church or the religious order or organization of which he is a member, such benefits will be paid, upon the request of such person, to such church or to such religious order or organization.

§ 71.6 Notice of injury or death.

Notwithstanding any of the provisions in part 61 of this chapter, no notice or report of injury or death shall be required for claims filed under this subchapter.

§ 71.7 Claim filing, processing, adjudication and time limits.

(a) Claims for injury, disability or death benefits payable under section 5(f) of the said War Claims Act of 1948, originating in the United States or in its Territories or possessions, shall be filed by mailing to the Bureau of Employees' Compensation, United States Department of Labor, Washington, DC 20211. All claims originating in the Philippine Islands may be filed by mailing to the Bureau of Employees' Compensation, United States Department of Labor, Manila, P.I. All claims will be finally processed and adjudicated by the Bureau at its principal office in Washington, DC.

(b) The limitation provisions for the filing of claims for disability or death benefits, as prescribed by applicable provisions of statute, shall not begin to run earlier than July 3, 1948.

CHAPTER II—RAILROAD RETIREMENT BOARD

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SUBCHAPTER A—GENERAL ADMINISTRATION

PART 200—GENERAL ADMINISTRATION

Sec.

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AUTHORITY: 45 U.S.C. 231f(b)(5) and 45 U.S.C. 362; §200.4 also issued under 5 U.S.C. 552; §200.5 also issued under 5 U.S.C. 552a; §200.6 also issued under 5 U.S.C. 552b; and §200.7 also issued under 31 U.S.C. 3717.

§200.1 Designation of central and field organization.

(a) *Introduction.* (1) The Railroad Retirement Board (hereinafter referenced as the ''Board'') is an independent agency in the executive branch of the Federal Government and is administered by three members appointed by the President, with the advice and consent of the Senate. By law, one member is appointed upon recommendations made by railroad labor organizations, one upon recommendations of railroad employers, and the third member, the Chairman, is in effect independent of employees and employers and represents the public interest. The terms of office are five years and are arranged so as to expire in different calendar years.

(2) The primary function of the Board is the determination and payment of benefits under the retirement-survivor and unemployment-sickness programs. To this end, the Board must maintain lifetime earnings records for covered employees, a network of field offices to assist railroad personnel and their dependents in filing claims for benefits, and examiners to adjudicate the claims.

(3) The Board administers the Railroad Retirement Act and the Railroad Unemployment Insurance Act. The Railroad Retirement Tax Act, which imposes employment taxes to fund the railroad retirement system, is administered by the Internal Revenue Service of the U.S. Department of Treasury. The Board also participates in the administration of the Federal Medicare health insurance program.

(4) The headquarters of the Board is in Chicago, Illinois, at 844 North Rush Street. The Board maintains numerous district offices across the country in localities easily accessible to large numbers of railroad workers, in addition to three regional offices located in Atlanta, Georgia; Denver, Colorado; and, Philadelphia, Pennsylvania.

(b) *Internal organization.* (1) Reporting directly to the Board Members is the six member Executive Committee. The Executive Committee is comprised of the General Counsel, who also serves as the Senior Executive Officer, the Director of Administration, the Director of Programs, the Chief Financial Officer, the Chief Information Officer, and the Chief Actuary.

(2) The Executive Committee is responsible for the day to day operations of the agency. The Senior Executive Officer is responsible for direction and oversight of the Executive Committee. The General Counsel is responsible for advising the Board Members on major issues, interpreting the Acts and regulations administered by the Board, drafting and analyzing legislation, and planning, directing, and coordinating the work of the Office of General Counsel, the Bureau of Hearings and Appeals, and the Office of Legislative Affairs through their respective directors, and the Office of Secretary to the Board. The Director of Programs is responsible for managing, coordinating, and controlling the program operations of the agency which carry out provisions of the Railroad Retirement and

Railroad Unemployment Insurance Acts. The Director of Administration is responsible for managing, coordinating, and controlling certain administrative operations of the Board including the Bureau of Supply and Service, the Bureau of Human Resources, the Office of Public Affairs, and the Office of Equal Opportunity. The Chief Financial Officer is responsible for the financial management of the agency, and the Chief Information Officer is responsible for coordinating the agency's information resources management program. The Board's Chief Actuary is responsible for the actuarial program of the Board. The Chief Actuary is a non-voting member of the Executive Committee.

(3) Further, the following offices provide administrative and other services in support of Board Operations: Office of Equal Employment Opportunity, Washington Legislative/Liaison Office, Office of Planning, Office of Public Affairs and Bureau of Quality Assurance.

(c) *Office of Inspector General.* The Railroad Retirement Solvency Act of 1983 established the Office of Inspector General within the Board to be governed by the Inspector General Act of 1978. As structured, the Inspector General reports directly to the Chairman. The Office of Inspector General is responsible for policy direction and conduct of audit, inspection, and investigation activities relating to program and operations of the Board; and maintaining liaison with other law enforcement agencies, the Department of Justice, and United States Attorneys on all matters relating to the detection and prevention of fraud and abuse. The Inspector General reports semi-annually to the Congress through the Chairman concerning fraud, abuses, other serious problems, and deficiencies of agency programs and operations; recommends corrective action; and, reports on progress made in implementing these actions.

[52 FR 11010, Apr. 6, 1987, as amended at 67 FR 5723, Feb. 7, 2002]

§ 200.2 The general course and method by which the Board's functions are channeled and determined.

(a) *Retirement and death benefits.* (1) Retirement and death benefits must be applied for by filing application therefor. (For details as to application, see parts 210 and 237 of this chapter). The Bureau of Retirement Claims considers the application and the evidence and information submitted with it. Wage and service records maintained by the Board are checked and if necessary, further evidence is obtained from the employee, the employer, fellow employees, public records and any other person or source available. The Bureau makes initial decisions on the following matters:

(i) Applications for benefits;

(ii) Requests for the withdrawal of an application;

(iii) Requests for a change in an annuity beginning date;

(iv) The termination of an annuity;

(v) The modification of the amount of an annuity or lump sum;

(vi) Requests for the reinstatement of an annuity which had been terminated or modified;

(vii) The existence of an erroneous payment;

(viii) The eligibility of an individual for a supplemental annuity or the amount of such supplemental annuity.

(ix) Whether representative payments shall serve the interests of an individual by reason of his incapacity to manage his annuity payments; and

(x) Who shall be appointed or continued as representative payee on behalf of an annuitant.

(2) A claimant dissatisfied with the Bureau's decision may, upon filing notice within one year from the date the decision is mailed to the claimant, appeal to the Bureau of Hearings and Appeals. *Provided, however,* That (i) an individual under age 16 shall not have the right to appeal a finding of incapacity to manage his annuity payments, but shall have the right to contest on appeal that he is, in fact, under age 16; (ii) an individual who has been adjudged legally incompetent shall not have the right to appeal a finding of incapacity to manage his annuity payments, but shall have the right to contest on appeal the fact of his having been adjudged legally incompetent; and (iii) an individual shall not have the right to appeal a denial of his application to serve as representative payee on behalf of an annuitant. There he

may have an oral hearing before a hearings officer of which a stenographic record is made, submit additional evidence, be represented, and present written and oral argument. If dissatisfied with the decision of the hearings officer, the claimant may appeal to the Board itself. This appeal must be made on a prescribed form within four months of the date a copy of the hearings officer's decision was mailed to him. If new evidence is received, the Board may remand the case to the hearings officer for investigation and recommendation concerning the new evidence. (For details on appeals procedure, see part 260 of this chapter.) A claimant, after he has unsuccessfully appealed to the Board itself and has thus exhausted all administrative remedies within the Board, may obtain a review of a final decision of the Board by filing a petition for review, within one year after the entry of the decision on the records of the Board and its communication to the claimant, in the U.S. Court of Appeals for the circuit in which the claimant resides, or in the U.S. Court of Appeals for the Seventh Circuit, or in the U.S. Court of Appeals for the District of Columbia Circuit.

(b) *Unemployment, sickness, and maternity benefits.* (1) Claims for unemployment benefits are handled by a comprehensive organization set up in the field. Under agreements between the Railroad Retirement Board and covered employers, the employers select employees of theirs to act as unemployment claims agents. These agents perform their services, specified in the agreement, in accordance with instructions issued by the Board but under general supervision and control of the employer. In accordance with the agreements, employers are reimbursed for such services at the rate of 50 cents for each claim taken by an unemployment claims agent and transmitted to the Board. There are some 13,000 such contract claims agents. An unemployed person who wishes to file a claim for unemployment benefits need only consult his recent railroad employer to be directed to the unemployment claims agent with whom he may file his claim.

(2) When an employee makes his first claim in any benefit year, he identifies himself and fills out an application for unemployment benefits (UI–1), an application for employment service (Form ES–1), and a pay rate report (Form UI 1a) to be used in determining the rate at which benefits may be paid. The employee is given an informational booklet UB–4 and an Unemployment Bulletin No. UB–3 informing him of his responsibilities and explaining the statements to which he is required to certify and to which he does certify when he registers for benefits. When the applications and pay rate report are completed, the unemployment claims agent sends them to the nearest field office of the Board. That office inspects the applications to detect errors and omissions and to note items requiring investigation. The office also attempts to verify the employee's statement about his pay rate unless the unemployment claims agent has already done so. The application for unemployment benefits and the pay rate report are then sent to the appropriate regional office of the Board. The application for employment service is retained in the field office for use in referring the claimant to suitable job openings. On the basis of the information furnished on the application for unemployment benefits, the regional office determines whether the applicant is a qualified employee (that is, whether he earned $500 or more from covered employment in the base year). The applicant is notified by letter if he is found to be not qualified.

(3) In addition to the application forms and pay rate report, the claimant executes a registration and claim for unemployment insurance benefits (Form UI–3). In substance, registration consists of his appearing before an unemployment claims agent during the agent's working hours and signing his name on the registration and claim form for the days he wishes to claim as days of unemployment. Registration for any day must be made on the day or not later than the sixth calendar day thereafter, except that, if such calendar day is not a business day, the claimant may make his registration on the next following business day. In other words, a claimant must ordinarily appear for registration at seven-

day intervals. Under certain circumstances, such as illness, employment, looking for employment, etc., an employee may make a delayed registration for any day for which he is unable to register within the time limit mentioned above. The unemployment claims agent sends the claim to the nearest field office where it is inspected with a view to calling the claimant in for interview or referral to job openings, detecting errors and omissions, and noting items requiring investigation. The claim is then forwarded to the regional office.

(4) Claims for sickness benefits are handled by the field organization of the Board. An employee need not register in person for sickness benefits but claims for such benefits must be made on the forms prescribed by the Board and executed by the individual claiming benefits except that, if the Board is satisfied that an employee is so sick or injured that he cannot sign forms, the Board may accept forms executed by someone else in his behalf. Forms used in connection with claims for sickness benefits may be obtained from a railroad employer, a railway labor organization, or any Board office. An application for sickness benefits (Form SI–1a) and the required statement of sickness (Form SI–1b) may be mailed to any office of the Board (see part 335 of this chapter). It is important that a statement of sickness be filed promptly, for no day can be considered as a day of sickness unless a statement of sickness with respect to such day is filed at an office of the Board within ten days. The application and statement of sickness are forwarded to a regional office where they are examined. If it appears that the employee is entitled to benefits, the regional office will send him a claim form covering a 14-day registration period, and a pay rate report (Form SI–1d). The employee completes the forms, indicating on the claim form the days during the period he claims as days of sickness and returns both forms to the regional office to which the claim form is preaddressed. When additional medical information is needed, a form for supplemental doctor's statement is sent to the employee. This should be filled out by a doctor and returned to the Board.

(5) Maternity benefits must be applied for on a form prescribed by the Board. A statement of maternity sickness, executed by a person authorized to execute statements of sickness (see part 335 of this chapter), is required also. The necessary forms may be obtained from a railroad employer, a railway labor organization, or any Board office. An application for maternity benefits (Form SI–101) and the statement of maternity sickness (Form SI–104) may be filed in person or by mail with any Board office. It is important that the statement of maternity sickness be filed promptly since no day can be considered as a day of sickness in a maternity period unless a statement of maternity sickness with respect to the day is filed at an office of the Board within ten days. As in the case of claims for sickness benefits, the forms are forwarded to a regional office. Claim forms are mailed to the claimant and are pre-addressed for return to the regional office.

(6) Whether benefits are payable to a claimant and, if so, the amount of benefits payable, is determined with respect to claims for unemployment, sickness, and maternity benefits, by the regional office. The names and addresses of claimants to whom benefits are found payable, and the amounts payable to them, are certified to the local disbursing office of the Treasury Department which mails the benefit checks to the claimants. If a claim is denied in whole or in part, an explanation is given to the claimant by letter.

(7) The rate at which benefits are payable is determined from the claimant's railroad wages earned in a base year period or from his daily pay rate for his last railroad employment in the base year period, whichever will result in the higher benefit rate. His daily benefit rate will be at least 60 per centum of his daily pay rate for his last railroad employment in the base year period, but not exceeding $10.20.

(8) Any qualified employee whose claim for benefits under the Railroad Unemployment Insurance Act has been denied in whole or in part may, within one year from the date such denial is communicated to him, appeal from the initial determination, and such appeal

will be heard before an impartial hearings officer. An unsuccessful claimant in an appeal before such hearings officer may appeal to the Board. (For further details of appeals procedure by claimants for benefits and for appeals procedure by employers, see parts 319 and 320 of this chapter.)

Any claimant, or any railway labor organization organized in accordance with the provisions of the Railway Labor Act, of which the claimant is a member, or any other party aggrieved by a final decision pursuant to the Railroad Unemployment Insurance Act, may, only after all administrative remedies within the Board will have been availed of and exhausted, obtain a review of such final decision of the Board by filing a petition for review within 90 days after the mailing of notice of such decision to the claimant or other party, or within such further time as the Board may allow, in the United States court of appeals for the circuit in which the claimant or other party resides or will have had his principal place of business or principal executive office, or in the United States Court of Appeals for the Seventh Circuit, or in the United States Court of Appeals for the District of Columbia Circuit.

(c) *Current compensation and service records.* Current compensation and service records are maintained by the Bureau of Research and Employment Accounts. These records are obtained from reports made periodically on either a quarterly or annual basis by employers and employee representatives. General instructions in this regard may be found in part 250 of this chapter. Special instructions to employers and employee representatives are issued from time to time by the Director of Research and Employment Accounts.

(d) *Collection of contributions.* The Office of Budget and Fiscal Operations acts as the collecting agency of the Board in receiving contributions due under the Railroad Unemployment Insurance Act. Contributions are, with some few exceptions, due quarterly and with the payment, the employer must file a report, Form DC–1, Employers Quarterly or Annual Report of Contributions under the Railroad Unemployment Insurance Act. (For further details see part 345 of this chapter.)

(e) *Employment service.* Employers needing workers may avail themselves of the Board's employment service by making requests of any field office for referrals, in writing, on forms provided by the Board, or by telephone.

[15 FR 6752, Oct. 6, 1950, as amended at 21 FR 4808, June 29, 1956; Board Order 62–115, 27 FR 9254, Sept. 19, 1962; Board Order 67–67, 32 FR 9064, June 27, 1967; 41 FR 22557, June 4, 1976. Redesignated at 52 FR 11010, Apr. 6, 1987, as amended at 55 FR 26430, June 28, 1990]

§ 200.3 Obtaining forms from the Railroad Retirement Board.

Forms used by the Board, including applications for benefits and informational publications, may be obtained from the Board's headquarters at 844 Rush Street, Chicago, Illinois 60611, and from local Board offices.

[63 FR 17326, Apr. 9, 1998]

§ 200.4 Availability of information to public.

(a) The following materials (more particularly described in paragraph (d) of this section), with identifying details deleted pursuant to paragraph (b) of this section, are available for public inspection and copying:

(1) All final opinions (including concurring and dissenting opinions), and all orders made in the adjudication of cases, which have precedential effect;

(2) All statements of policy and interpretations which have been adopted by the Board, or by anyone under authority delegated by the Board, which have not been published in the FEDERAL REGISTER; and

(3) Administrative staff manuals and instructions to staff that affect any member of the public.

(b) The identifying details to be deleted shall include, but not be limited to, names and identifying numbers of employees and other individuals as needed to comply with sections 12(d) and (n) of the Railroad Unemployment Insurance Act, section 7(b)(3) of the Railroad Retirement Act, and § 200.8 of this part, or to prevent a clearly unwarranted invasion of personal privacy.

(c) There shall be maintained in the Board's library a current index of the materials referred to in paragraph (a)

of this section which will have been issued, adopted, or promulgated subsequent to July 4, 1967. This index shall be available for public inspection and copying at the Board's headquarters offices located at 844 Rush Street, Chicago, Illinois, during the normal business hours of the Board. Copies of the index or any portion thereof may be obtained for a fee equivalent to the costs of reproduction by submitting a written request therefor. Such request should comply with the form for requests as described in paragraph (h) of this section.

(d) The materials and indexes thereto shall be kept, and made available to the public upon request, in the bureaus and offices of the Board that produce or utilize the materials. The following materials currently in use shall, as long as they are in effect as precedents and instructions, be made available in offices of the Board at 844 North Rush Street, Chicago, Illinois 60611–2092:

(1) In the Office of Programs/Operations: The Retirement Claims Manual, RCM Circulars, Special Services Manual, Policy Decisions, Procedural Memoranda containing information on the adjudication of claims not contained in the Retirement Claims Manual or in RCM Circulars, Field Operating Manual (Parts I and VI), FOM Circulars and Memoranda, the Occupational Disability Rating Schedule, Adjudication Instruction Manual, Regional Operating Manual (Part I), memorandum instructions on adjudication, and circular letters of instruction to railroad officials.

(2) In the Office of Programs/Assessment and Training: The Instructions to Employers, and Circular Letters to Employers.

(3) In the Office of General Counsel: Legal Opinions.

(4) In the Office of the Secretary to the Board: Decisions and rulings of the Board.

(5) Regional offices and field offices shall also make available to the extent practicable such of these materials and indexes as are furnished them in the ordinary course of business.

(e) The copies of manuals and instructions made available for public copying and inspection shall not include:

(1) Confidential statements, standards, and instructions which do not affect the public, and

(2) Instructions not affecting the public (such as those relating solely to processing and procedure, to management, or to personnel) which it is feasible to separate from instructions that do affect the public.

(f) With the exception of records specifically excluded from disclosure by section 552(b) of title 5, United States Code, or other applicable statute, any records of or in the custody of this agency, other than those made available under paragraphs (a), (c), and (d) of this section, shall, upon receipt of a written request reasonably describing them, promptly be made available to the person requesting them.

(g) The RRB may charge the person of persons making a request for records under paragraph (f) of this section a fee in an amount not to exceed the costs actually incurred in complying with the request and not to exceed the cost of processing a check for payment. Depending on the category into which the request falls, a fee may be assessed for the cost of search for documents, reviewing documents to determine whether any portion of any located documents is permitted to be withheld, and duplicating documents.

(1) *Fee schedule.* To the extent that the following are chargeable, they are chargeable according to the following schedule:

(i) The charge for making a manual search for records shall be the salary rate, including benefits, for a GS–7, step 5 Federal employee;

(ii) The charge for reviewing documents to determine whether any portion of any located document is permitted to be withheld shall be the salary rate, including benefits, for a GS–13, step 5 Federal employee;

(iii) The charge for making photocopies of any size document shall be $.10 per copy per page:

(iv) The charge for computer-generated listings or labels shall include the direct cost to the RRB of analysis and programming, where required, plus the cost of computer operations to produce the listing or labels. The maximum computer search charge shall be $2,250.00 per hour ($37.50 per minute).

Search time shall not include the time expended in analysis or programming where these operations are required.

(v) There shall be no charge for transmitting documents by regular post. The charge for all other methods of transmitting documents shall be the actual cost of transmittal.

(2) *Categories of requesters.* For the purpose of assessing fees, requesters shall be classified into one of the following five groups:

(i) *Commercial use requesters.* Commercial use requesters are requesters who seek information for a use or purpose that furthers the commercial, trade, or profit interests of the requester or the person on whose behalf the request is made. For such requesters, the RRB will fully charge for the cost of searching, reviewing and copying and shall not consider a request for waiver or reduction of fees based upon an assertion that disclosure would be in the public interest; however, the RRB will not charge a fee if the total cost for searching, reviewing, and copying is less than $10.00.

(ii) *Educational and non-commercial scientific institution requesters.* Educational requesters are educational institutions which operate a program or programs of scholarly research. They may be a preschool, a public or private elementary or secondary school, an institution of graduate higher education, an institution of undergraduate higher education, an institution of professional education, or an institution of vocational education. Non-commercial scientific requesters are institutions that are not operated on a ''commercial'' basis and which are operated solely for the purpose of conducting scientific research the results of which are not intended to promote any particular product or industry. To be eligible for inclusion in this category, requesters must show that the request is being made under the auspices of a qualifying institution and that the records are not sought for a commercial use, but are sought in furtherance of scholarly (if the request is from an educational institution) or scientific (if the request is from a non-commercial scientific institution) research. For requesters in this category, the RRB shall charge for the cost of reproduction alone, excluding the first 100 pages, for which no charge will be made. If after excluding the cost of the first 100 pages of reproduction, there remain costs to be assessed, the RRB will not charge for such costs is such costs total less than $10.00. If the cost is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. To be eligible for free search time, these requesters must reasonably describe the records sought.

(iii) *Requesters who are representatives of the news media.* The term ''representative of the news media'' refers to any person actively gathering news for an entity that is organized and operated to publish or broadcast news to the public. The term ''news'' means information that is about current events or that could be of interest to the public. In the case of ''freelance'' journalists, they may be regarded as working for a news organization if they can demonstrate a solid basis for expecting publication through that organization, even though not actually employed by it. For requesters in this category the RRB shall charge for the cost of reproduction alone excluding the cost of the first 100 pages, for which no charge will be made. If, after excluding the cost of the first 100 pages of reproduction, there remain costs to be assessed, the RRB will not charge for such costs if such costs total less than $10.00. If the cost is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester. To be eligible for free search time, these requesters must reasonably describe the record sought.

(iv) *Requests by subjects of records in Privacy Act Systems of Records.* Requests from subject individuals for records about themselves filed in any of the Board's Privacy Act Systems of records will continue to be treated under the

fee provisions of the Privacy Act of 1984 which permit assessing fees only for reproduction.

(v) *All other requesters.* For requesters who do not fall within the purview of paragraph (g)(2)(i), (ii), (iii), or (iv) of this section, the RRB will charge the full direct cost of searching for and reproducing records that are responsive to the request. The RRB will not charge for such costs to be assessed if the total is less than $10.00. If the total is $10.00 or more, the RRB may waive the charge or reduce it if it determines that disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

(3) *Charges for unsuccessful searches.* Where search time is chargeable, the RRB may assess charges for time spent searching, even if the RRB fails to locate the records, or if located, the records are determined to be exempt from disclosure. If the Board estimates that search charges are likely to exceed $25.00 it will notify the requester of the estimated amount of fees, unless the requester has agreed in advance to pay fees as high as those anticipated. Such notice will offer the requester the opportunity to confer with agency personnel with the object of reformulating the request to meet his or here needs at a lower cost.

(4) *Aggregating requests.* When the RRB reasonably believes that a requester or group of requesters acting in concert is attempting to break a request into a series of requests for the purpose of evading the assessment of fees, the RRB will aggregate any such requests and charge accordingly. One element the RRB will consider in determining whether a belief would be reasonable is the time period in which the requests have been.

(5) *Advance payments.* (i) The RRB estimates or determines that the allowable charges payment unless:

(A) The RRV estimates or determines that the allowable charges that a requester may be required to pay are likely to exceed $250.00, in which case the RRV will notify the requester of the likely cost and obtain satisfactory assurance of full payment where the requester has a history of prompt payment of FOIA fees, or require an advance payment of an amount up to the full estimated charges in the case of requesters with no history of payment; or

(B) A requester has previously failed to pay a fee charged in a timely fashion (i.e., within 30 days of the date of the billing), in which case the RRB may require the requester to pay the full amount owed plus any applicable interest as provided below of demonstrate that he has, in fact, paid the fee, and to make an advance payment of the full amount of the estimated fee before the agency begins to process a new request or a pending request from that requester.

(ii) When the Board acts under paragraph (g)(5)(i) of this section, the administrative time limits prescribed in subsection (a)(6) of the Freedom of Information Act (5 U.S.C. 552(a)(6)) (i.e., 10 working days from receipt of initial requests and 20 working days from receipt of appeals from initial denials, plus permissible extensions of these time limits) will begin only after the Board has received the fee payments described in said paragraph (g)(5)(i) of this section.

(6) *Charging interest.* Interest may be charged to any requester who fails to pay fees charged within 30 days fo the date of billing. Interest will be assessed beginning on the 31st day following the day on which the bill for fees was sent. Interest will be the rate prescribed in section 3717 of title 31 of the U.S. Code Annotated and will accrue from the date of the billing.

(7) *Collection of fees due.* Whenever it is appropriate in the judgment of the Board in order to encourage repayment of fees billed in accordance with these regulations, the Board will use the procedures authorized by the Debt Collection Act of 1982 (Pub. L. 97–365), including disclosure to consumer reporting agencies and use of collection agencies.

(h) Any person or organization requesting records pursuant to this section shall submit such request in writing to the General Counsel, Railroad Retirement Board, Room 836, 844 North Rush Street, Chicago, Illinois 60611–

2092. All such requests should be clearly and prominently identified as requests for information under the Freedom of Information Act. If submitted by mail or otherwise submitted in an envelope or other cover, requests should be clearly and prominently identified as such on the envelope or cover. Requests may also be submitted by e-mail, *LAWGroupMailbox@rrb.gov*.

(i) The General Counsel, or any other individual specifically authorized to act on behalf of the General Counsel, shall have the authority to grant or deny a request for information submitted under this section. The General Counsel or such authorized representative shall, within 20 working days following the receipt of a request, except as provided in paragraph (j)(1) of this section, make a determination granting or denying the request and notify the requester of his or her decision, and if a denial, the reasons therefor. The requester shall be further advised that a total or partial denial may be appealed to the Board as provided in paragraph (j) of this section.

(j) In cases where a request for information is denied, in whole or in part, by the General Counsel or his or her authorized representative, the party who originally made the request may appeal such determination to the Board by filing a written appeal with the Secretary of the Board within 20 working days following receipt of the notice of denial. The Board shall render a decision on an appeal within 20 working days following receipt of the appeal except as provided in paragraph (j)(1) of this section. The requester shall promptly be notified of the Board's decision and, in cases where the denial is upheld, of the provisions for judicial review of such final administrative decisions.

(1) In unusual circumstances, as enumerated in section 552(a)(6)(B) of title 5, United States Code, the time restrictions of paragraphs (i) and (j) of this section may be extended in the aggregate by no more than 10 days by notice to the requester of such extension, the reasons therefor, and the date on which a determination is expected to be dispatched.

(2) For purposes of paragraphs (i) and (j) of this section, a request shall be received by the General Counsel of the Board when it arrives at the Board's headquarters. *Provided, however,* That when the estimated fee to be assessed for a given request exceeds $30.00, such request shall be deemed not to have been received by the General Counsel until the requester is advised of the estimated cost and agrees to bear it. *Provided further,* That a request which does not fully comply with all the provisions of paragraph (h) of this section shall be deemed to have been received by the General Counsel on the day it actually reaches his or her office.

(k) Any person in the employ of the Railroad Retirement Board who receives a request for any information, document or record of this agency, or in the custody thereof, shall advise the requester to address such request to the General Counsel. If the request received is in writing, it shall be immediately referred for action to the Executive Director.

(l) The General Counsel shall maintain records of:

(1) The total amount of fees collected by this agency pursuant to this section;

(2) The number of initial denials of requests for records made pursuant to this section and the reason for each;

(3) The number of appeals from such denials and the result of each appeal, together with the reason(s) for the action upon each appeal that results in a denial of information;

(4) The name(s) and title(s) or position(s) of each person responsible for each initial denial of records requested and the number of instances of action on a request for information for each such person;

(5) The results of each proceeding conducted pursuant to section 552(a)(4)(F) of title 5 U.S. Code, including a report of any disciplinary action against an official or employee who was determined to be primarily responsible for improperly withholding records, or an explanation of why disciplinary action was not taken;

(6) Every rule made by this agency affecting or in implementation of section 552 of title 5 U.S. Code;

(7) The fee schedule for copies of records and documents requested pursuant to this regulation; and

(8) All other information which indicates efforts to administer fully the letter and spirit of section 552 of title 5 U.S. Code.

(m) The Board shall, prior to February 1 of each year, prepare and submit a report to the Attorney General of the United States covering each of the categories of records maintained in accordance with the foregoing for the preceding fiscal year.

(n) *Special procedures for handling requests for business information:*

(1) The Freedom of Information Act exempts from mandatory disclosure matters that are ''trade secrets and commercial or financial information obtained from a person and privileged or confidential * * *.'' The Board maintains records that may include information within this exception and to protect the rights of submitters of business information with respect to the confidentiality of such information, all requests for records or information contained in contract bids, contract proposals, contracts, and similar business information documents shall be handled in accordance with the procedures established by this paragraph.

(2) When the Executive Director or an individual authorized to grant or deny requests under the Freedom of Information Act receives a request for business information, the General Counsel or other individual shall promptly provide the person who submitted the information to the Board with written notice that a request for the information has been made. The notice shall specify what record or information has been requested and shall inform the business submitter that the submitter may, within ten working days after the date of the notice, file a written objection to disclosure of the information or portions of the information. The written objection to disclosure shall be addressed to the individual whose name appears in the notification and shall specify the portion or portions of the information that the submitter believes should not be disclosed and state the grounds or bases for objecting to disclosure of such portion or portions. No written notice to the business submitter shall be required under this subparagraph if it is readily determined that the information will not be disclosed or that the information has lawfully been published or otherwise made available to the public.

(3) In determining whether to grant or deny the request for the business information, the official or entity making the determination shall carefully consider any objection to disclosure made by the submitter of the information in question.

(4) If a determination is made to disclose information with respect to which the business submitter has filed an objection to disclosure, the official or entity making the determination shall, no later than ten working days prior to the date on which disclosure of the information will be made, provide the submitter with written notice of the determination to disclose. The written notice shall state the reasons why the submitter's grounds for objecting to disclosure were rejected and inform the submitter of the date on which the information is to be disclosed.

(5) The Board shall promptly notify the business submitter of any suit commenced under the Freedom of Information Act to compel disclosure of information which he or she submitted to the Board.

(o) *Custom tailored information services; Fees charged.* This paragraph and paragraph (p) of this section set forth the policy of the Railroad Retirement Board with respect to the assessment of a fee for providing custom tailored information where requested. Except as provided in paragraphs (o)(4)(vii) and (p) of this section, a fee shall be charged for providing custom tailored information.

(1) *Definition: Custom tailored information.* Custom tailored information is information not otherwise required to be disclosed under this part but which can be created or extracted and manipulated, reformatted, or otherwise prepared to the specifications of the requester from existing records. For example, the Board needs to program computers to provide data in a particular format or to compile selected items from records, provide statistical data, ratios, proportions, percentages, etc. If this data is not already compiled and available, the end product would be

the result of custom tailored information services.

(2) *Providing custom tailored information.* The Board is not required to provide custom tailored information. It will do so only when the appropriate fees have been paid as provided in paragraph (o)(4) of this section and when the request for such information will not divert staff and equipment from the Board's primary responsibilities.

(3) *Requesting custom tailored information.* Information may be requested in person, by telephone, or by mail. Any request should reasonably describe the information wanted and may be sent to the Director of Administration, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611–2092.

(4) *Fee schedule.* Requests for custom tailored information are chargeable according to the following schedule:

(i) *Manual searching for records.* Full cost of the time of the employees who perform the service, even if records cannot be found, management and supervisory costs, plus the full costs of any machine time and materials the employee uses. Consulting and other indirect costs will be assessed as appropriate.

(ii) *Photocopying or reproducing records on magnetic tapes or computer diskettes.* The charge for making photocopies of any size document shall be $.10 per copy per page. The charge for reproducing records on magnetic tapes or computer diskettes is the full cost of the operator's time plus the full cost of the machine time and the materials used.

(iii) *Use of electronic data processing equipment to obtain records.* Full cost for the service, including computer search time and computer runs and printouts, and the time of computer programmers and operators and of other employees.

(iv) *Certification or authentication.* Full cost of certification and authentication.

(v) *Providing other special services.* Full cost of the time of the employee who performs the service, management and supervisory costs, plus the full costs of any machine time and materials the employee uses. Consulting and other indirect costs will be assessed as appropriate.

(vi) *Special forwarding arrangements.* Full cost of special arrangements for forwarding material requested.

(vii) *Statutory supersession.* Where a Federal statute prohibits the assessment of a charge for a service or addresses an aspect of that charge, the statute shall take precedence over this paragraph (o).

(p) *Assessment of a fee with respect to the provision of custom tailored information where the identification of the beneficiary is obscure and where provision of the information can be seen as benefiting the public generally.* When the identification of a specific beneficiary with respect to the provision of custom tailored information is obscure, the service can be considered primarily as benefiting broadly the general public, and the estimated cost of providing the information is less than $1,000.00, the Director of Administration shall determine whether or not a fee is to be charged. In any such case where the cost is $1,000.00 or more, the request shall be referred by the Director of Administration to the three-member Board for a determination whether or not a fee is to be assessed.

[Board Order 6784, 32 FR 9651, Sept. 4, 1967, as amended at 40 FR 7255, Feb. 19, 1975; 48 FR 51447, 51448, Nov. 9, 1983; 50 FR 26357, June 26, 1985. Redesignated at 52 FR 11010, Apr. 6, 1987, as amended at 52 FR 13820, Apr. 24, 1987; 54 FR 43055, Oct. 20, 1989; 59 FR 28765, June 3, 1994; 60 FR 29984, June 7, 1995; 61 FR 25390, May 21, 1996; 68 FR 61621, Oct. 29, 2003]

§ 200.5 Protection of privacy of records maintained on individuals.

(a) *Purpose and scope.* The purpose of this section is to establish specific procedures necessary for compliance with the Privacy Act of 1974 (Pub. L. 93–579). These regulations apply to all record systems containing information of a personal or private nature maintained by the Railroad Retirement Board that are indexed and retrieved by personal identifier.

(b) *Definitions*—(1) *Individual.* The term ''individual'' pertains to a natural person who is a citizen of the United States or an alien lawfully admitted for permanent residence and not to a company or corporation.

(2) *System of records.* For the purposes of this section, the term ''system of records'' pertains to only those records

that can be retrieved by an individual identifier.

(3) *Railroad Retirement Board.* For purposes of this section, the term ''Railroad Retirement Board'' refers to the United States Railroad Retirement Board, an independent agency in the executive branch of the United States Government.

(4) *Board.* For purposes of this section the term ''Board'' refers to the three member governing body of the United States Railroad Retirement Board.

(c) *Procedure for requesting the existence of personally identifiable records in a record system.* An individual can determine if a particular record system maintained by the Railroad Retirement Board contains any record pertaining to him by submitting a written request for such information to the system manager of that record system as described in the annual notice published in the FEDERAL REGISTER. A current copy of the system notices, published in accordance with paragraph (i) of this section, is available for inspection at all regional and district offices of the Board. If necessary, Board personnel will aid requesters in determining what system(s) of records they wish to review and will forward any requests for information to the appropriate system manager. Also, requests for personal information may be submitted either by mail or in person to the system manager at the headquarters of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Prior to responding to a request for information under this subsection, the system manager shall require the individual requesting such information to provide identifying data, such as his full name, date of birth, and social security number. The system manager shall respond to a request under this subsection within a reasonable time by stating that a record on the individual either is or is not contained in the system.

(d) *Disclosure of requested information to individuals.* (1) Upon request, an individual shall be granted access to records pertaining to himself, other than medical records and records compiled in anticipation of a civil or criminal action or proceeding against him, which are indexed by individual identifier in a particular system of records. Requests for access must be in writing and should be addressed to the system manager of that record system as described in the annual notice published in the FEDERAL REGISTER. Requests under this subsection may be submitted either by mail or in person at the headquarters offices of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611.

(2) The system manager shall, within ten working days following the date on which the request is received in his office, render a decision either granting or denying access and shall promptly notify the individual of his decision. If the request is denied, the notification shall inform the individual of his right to appeal the denial to the Board. An individual whose request for access under this subsection has been denied by the system manager may appeal that determination to the Board by filing a written appeal with the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611 within twenty working days following receipt of the notice of denial. The Board shall render a decision on an appeal within thirty working days following the date on which the appeal is received in the office of the Secretary of the Board. The individual shall promptly be notified of the Board's decision.

(3) In cases where an individual has been granted access to his records, the system manager shall, prior to releasing such records, require the individual to produce identifying data such as his name, date of birth, and social security number.

(4) Disclosure to an individual of his record may be made by providing him, upon written request therefor, a copy of the record or portion thereof which he reasonably describes in his request.

(5) An individual, and if such individual so desires, one other person of his choosing, may review and have a copy made of his record (in a form comprehensible to him) during regular business hours at the location described as the repository of the record system containing such records in the annual notice published in the FEDERAL REGISTER or at such other location convenient to the individual as

specified by the system manager. If an individual is accompanied by another person, the system manager may require written authorizations for disclosure in the presence of the other person from the individual before any record or portion thereof is released.

(e) *Special procedures—medical records.* (1) An individual concerning whom the Railroad Retirement Board maintains medical records in a system of records shall, upon written request, be permitted to review such medical records or be furnished copies of such records if the system manager of the system containing the requested records determines that disclosure of the records or any portion thereof would not be harmful to the individual's mental or physical health.

(2) If, upon review of the medical records requested, the system manager determines that disclosure of such records or any portion thereof might be harmful to the individual's mental or physical health, he shall inform the individual that copies of the records may be furnished to a physician of the individual's own choosing. If the individual should select a physician to conduct such a review and direct the Board to permit the physician to review the records, the system manger shall promptly forward copies of the records in question to that physician. The system manger shall inform the physician that the records are being provided to him or her for the purpose of making an independent determination as to whether release or the records directly to the individual who has requested them might be harmful to that individual. The physician shall be informed that if, in his or her opinion, direct disclosure of the records would not be harmful to the individual's mental or physical health, he or she may then provide the copies to the individual. The physician shall further be informed that should he or she determine that disclosure of the records in question might be harmful to the individual, such records shall not be disclosed and should be returned to the Board, but the physician may summarize and discuss the contents of the records with the individual.

(3) The special procedure established by paragraph (e) of this section to permit an individual access to medical records pertaining to himself or herself shall not be construed as authorizing the individual to direct the Board to disclose such medical records to any third parties, other than to a physician in accordance with paragraph (e)(2) of this section. Medical records shall not be disclosed by the Board to any entities or persons other than the individual to whom the record pertains or his or her authorized physician regardless of consent, except as permissible under paragraphs (j)(1)(i), (iii), and (viii) of this section and as provided under paragraph (e)(4) of this section.

(4) Notwithstanding the provisions of paragraphs (e)(1), (2) and (3) of this section and of paragraph (d) of this section, if a determination made with respect to an individual's claim for benefits under the Railroad Retirement Act of the Railroad Unemployment Insurance Act is based in whole or in part on medical records, disclosure of or access to such medical records shall be granted to such individual or to such individual's representative when such records are requested for the purpose of contesting such determination either administratively of judicially.

(5) The procedures for access to medical records set forth in paragraph (e) of this section shall not apply with respect to requests for access to an individual's disability decision sheet or similar adjudicatory documents, access to which is governed solely by paragraph (d) of this section.

(f) *General exemptions*—(1) *Systems of records subject to investigatory material exemption under 5 U.S.C. 552a(j)(2).* RRB–43, Investigation Files, a system containing information concerning alleged violations of law, regulation, or rule pertinent to the administration of programs by the RRB or alleging misconduct or conflict of interest on the part of RRB employees in the discharge of their official duties.

(2) *Scope of exemption.* (i) The system of records identified in this paragraph is maintained by the Office of Investigations (OI) of the Office of Inspector General (OIG), a component of the Board which performs as its principal function activities pertaining to the enforcement of criminal laws. Authority for the criminal law enforcement

activities of the OIG's OI is the Inspector General Act of 1978, 5 U.S.C. App.

(ii) Applicable information in the system of records described in this paragraph is exempt from subsections (c)(3) and (4) (Accounting of Certain Disclosures), (d) (Access to Records), (e)(1), (2), (3), (4)(G), (H), and (I), (5), and (8), (Agency Requirements), (f) (Agency Rules) and (g) (Civil Remedies) of 5 U.S.C. 552a.

(iii) To the extent that information in this system of records does not fall within the scope of this general exemption under 5 U.S.C. 552(j)(2) for any reason, the specific exemption under 5 U.S.C. 552(k)(2) is claimed for such information. (See paragraph (g) of this section.)

(3) *Reasons for exemptions.* The system of records described in this section is exempt for one or more of the following reasons:

(i) 5 U.S.C. 552a(c)(3) requires an agency to make available to the individual named in the records, at his or her request, an accounting of each disclosure of records. This accounting must state the date, nature, and purpose of each disclosure of a record and the name and address of the recipient. Accounting of each disclosure would alert the subjects of an investigation to the existence of the investigation and the fact that they are subjects of an investigation. The release of such information to the subjects of an investigation would provide them with significant information concerning the nature of the investigation, and could seriously impede or compromise the investigation and lead to the improper influencing of witnesses, the destruction of evidence, or the fabrication of testimony.

(ii) 5 U.S.C. 552a(c)(4) requires an agency to inform any person or other agency about any correction or notation of dispute made by the agency in accordance with subsection (d) of the Act. Since the RRB is claiming that this system of records is exempt from subsection (d) of the Act, concerning access to records, this section is inapplicable and is exempted to the extent that this system of records is exempted from subsection (d) of the Act.

(iii) 5 U.S.C. 552a(d) requires an agency to permit an individual to gain access to records pertaining to him or her, to request amendment of such records, to request a review of an agency decision not to amend such records, and to contest the information contained in such records. Granting access to records in this system of records could inform the subject of the investigation of an actual or potential criminal violation of the existence of that investigation, of the nature and scope of the information and evidence obtained as to his or her activities, of the identity of confidential sources, witnesses, and law enforcement personnel, and could provide information to enable the subject to avoid detection or apprehension. Granting access to such information could seriously impede or compromise an investigation, lead to the improper influencing of witnesses, the destruction of evidence, or the fabrication of testimony, and disclose investigative techniques and procedures.

(iv) 5 U.S.C. 552a(e)(1) requires each agency to maintain in its records only such information about an individual as is relevant and necessary to accomplish a purpose required by statute or executive order of the President. The application of this provision could impair investigations and law enforcement, because it is not always possible to detect the relevance or necessity of specific information in the early stages of an investigation. Relevance and necessity are often questions of judgment and timing, and it is only after the information is evaluated that the relevance and necessity of such information can be established.

(v) 5 U.S.C. 552a(e)(2) requires an agency to collect information to the greatest extent practicable directly from the subject individual when the information may result in adverse determinations about an individual's rights, benefits, and privileges under Federal programs. The application of this provision could impair investigations and law enforcement by alerting the subject of an investigation of the existence of the investigation, enabling the subject to avoid detection or apprehension, to influence witnesses improperly, to destroy evidence, or to fabricate testimony. Moreover, in certain

circumstances the subject of an investigation cannot be required to provide information to investigators, and information must be collected from other sources. Furthermore, it is often necessary to collect information from sources other than the subject of the investigation to verify the accuracy of the evidence collected.

(vi) 5 U.S.C. 552a(e)(3) requires an agency to inform each person whom it asks to supply information, on a form that can be retained by the person, of the authority under which the information is sought and whether disclosure is mandatory or voluntary; of the principal purposes for which the information is intended to be used; of the routine uses which may be made of the information; and of the effects on the person, if any, of not providing all or any part of the requested information. The application of this provision could provide the subject of an investigation with substantial information about the nature of that investigation.

(vii) 5 U.S.C. 552a(e)(4)(G) and (H) require an agency to publish a FEDERAL REGISTER notice concerning its procedures for notifying an individual at his request if the system of records contains a record pertaining to him or her, how he or she can gain access to such a record, and how he or she can contest its contents. Since the RRB is claiming that the system of records is exempt from subsection (f) of the Act, concerning agency rules, and subsection (d) of the Act, concerning access to records, these requirements are inapplicable and are exempted to the extent that these systems of records are exempted from subsections (f) and (d) of the Act. Although the RRB is claiming exemption from these requirements, RRB has published such a notice concerning its notification, access, and contest procedures because, under certain circumstances, RRB might decide it is appropriate for an individual to have access to all or a portion of his or her records in this system of records.

(viii) 5 U.S.C. 552a(e)(4)(I) requires an agency to publish in the FEDERAL REGISTER notice concerning the categories of sources or records in the system of records. Exemption from this provision is necessary to protect the confidentiality of the sources of information, to protect the privacy of confidential sources and witnesses, and to avoid the disclosure of investigative techniques and procedures. Although RRB is claiming exemption from this requirement, RRB has published such a notice in broad generic terms in the belief that this is all subsection (e)(4)(I) of the Act requires.

(ix) 5 U.S.C. 552a(e)(5) requires an agency to maintain its records with such accuracy, relevance, timeliness, and completeness as is reasonably necessary to assure fairness to the individual in making any determination about the individual. Since the Act defines ''maintain'' to include the collection of information, complying with this provision would prevent the collection of any data not shown to be accurate, relevant, timely, and complete at the moment it is collected. In collecting information for criminal law enforcement purposes, it is not possible to determine in advance what information is accurate, relevant, timely, and complete. Facts are first gathered and then placed into a logical order to prove or disprove objectively the criminal behavior of an individual. Material which may seem unrelated, irrelevant, or incomplete when collected may take on added meaning or significance as the investigation progresses. The restrictions of this provision could interfere with the preparation of a complete investigative report, thereby impending effective law enforcement.

(x) 5 U.S.C. 552a(e)(8) requires an agency to make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record. Complying with this provision could prematurely reveal an ongoing criminal investigation to the subject of the investigation.

(xi) 5 U.S.C. 552a(f)(1) requires an agency to promulgate rules which shall establish procedures whereby an individual can be notified in response to his or her request if any system of records named by the individual contains a record pertaining to him or her. The application of this provision could impede or compromise an investigation

or prosecution if the subject of an investigation was able to use such rules to learn of the existence of an investigation before it could be completed. In addition, mere notice of the fact of an investigation could inform the subject or others that their activities are under or may become the subject of an investigation and could enable the subjects to avoid detection or apprehension, to influence witnesses improperly, to destroy evidence, or to fabricate testimony. Since the RRB is claiming that these systems of records are exempt from subsection (d) of the Act, concerning access to records, the requirements of subsections (f)(2) through (5) of the Act, concerning agency rules for obtaining access to such records, are inapplicable and are exempted to the extent that this system of records is exempted from subsection (d) of the Act. Although RRB is claiming exemption from the requirements of subsection (f) of the Act, RRB has promulgated rules which establish Agency procedures because, under certain circumstances, it might be appropriate for an individual to have access to all or a portion of his or her records in this system of records. These procedures are described elsewhere in this part.

(xii) 5 U.S.C. 552a(g) provides for civil remedies if an agency fails to comply with the requirements concerning access to records under subsections (d)(1) and (3) of the Act; maintenance of records under subsection (e)(5) of the Act; and any rule promulgated thereunder, in such a way as to have an adverse effect on an individual. Since the RRB is claiming that this system of records is exempt from subsections (c)(3) and (4), (d), (e)(1), (2), (3), (4)(G), (H), and (I), (5), and (8), and (f) of the Act, the provisions of subsection (g) of the Act are inapplicable and are exempted to the extent that this system or records is exempted from those subsections of the Act.

(g) *Specific exemptions*—(1) *Systems of records subject to investigatory material exemption under 5 U.S.C. 552a(k)(2).* RRB–43, Investigation Files, a system containing information concerning alleged violations of law, regulation, or rule pertinent to the administration of programs by the RRB or alleging misconduct or conflict of interest on the part of RRB employees in the discharge of their official duties.

(2) *Privacy Act provisions from which exempt.* The system of records described in this paragraph is exempt from subsections (c)(3) (Accounting of Certain Disclosures), (d) (Access to Records), (e)(1), 4G, H, and I (Agency Requirements), and (f) (Agency Rules) of 5 U.S.C. 552a.

(3) *Reasons for exemptions.* The system of records described in this section is exempt for one or more of the following reasons:

(i) To prevent the subject of the investigations from frustrating the investigatory process.

(ii) To protect investigatory material compiled for law enforcement purposes.

(iii) To fulfill commitments made to protect the confidentiality of sources and to maintain access to necessary sources of information.

(iv) To prevent interference with law enforcement proceedings.

(h) *Request for amendment of a record.* (1) An individual may request that a record pertaining to himself be amended by submitting a written request for such amendment to the system manager as described in the annual notice published in the FEDERAL REGISTER. Requests under this subsection may be made either by mail or in person at the headquarters offices of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Such a request should include a statement of the information in the record which the individual believes is incorrect, a statement of any information not in the record which the individual believes would correct the record, if included, and a statement of any evidence which substantiates the individual's belief concerning the inaccuracy of the information presently contained in the record.

(2) Prior to rendering a determination in response to a request under this subsection, the system manager shall require that the individual provide identifying data such as his name, date of birth, and social security number.

(3) The system manager responsible for the system of records which contains the challenged record shall acknowledge receipt of the request in

writing within ten working days following the date on which the request for amendment was received in his office and shall promptly render a decision either granting or denying the request.

(i) If the system manager grants the individual's request to amend his record, the system manager shall amend the record accordingly, advise the individual in writing that the requested amendment has been made and where an accounting of disclosures has been made, advise all previous recipients of the record to whom disclosure of such record was made and accounted for of the fact that the amendment was made and the substance of the amendment.

(ii) If the system manager denies the individual's request to amend his record, the system manager shall inform the individual that the request has been denied in whole or in part, the reason for the denial and the procedure regarding the individual's right to appeal the denial to the Board.

(i) *Appeal of initial adverse determination on amendment.* (1) An individual, whose request for amendment of a record pertaining to him is denied, may appeal that determination to the Board by filing a written appeal with the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. The written notice of appeal should include a statement of the information in the record which the individual believes is correct, a statement of any information not in the record which the individual believes would correct the record, if included, and a statement of any evidence which substantiates the individual's belief concerning the inaccuracy of the information presently contained in the record.

(2) The Board shall consider the appeal and render a final decision thereon within thirty working days following the date on which the appeal is received in the office of the Secretary of the Board. An extension of the thirty day response period is permitted for a good cause upon notification of such to the requester.

(3) If, upon consideration of the appeal, the Board upholds the denial, the appellant shall be so informed in writing. The appellant shall be advised that he may file a concise statement with the Board setting forth his reasons for disagreeing with the Board's decision and the procedures to be followed in filing such a statement of disagreement. The individual shall also be informed of his right to judicial review as provided under section 552a(g)(1)(A) of title 5 of the United States Code. If disclosure has or will be made of a record containing information about which an individual has filed a statement of disagreement, that contested information will be annotated and a copy of the statement of disagreement will be provided to past and future recipients of the information along with which the Board may include a statement of its reasons for not amending the record in question.

(4) If, upon consideration of the appeal, the Board reverses the denial, the Board shall amend the record, advise the appellant in writing that such amendment has been made, and where an accounting of disclosures has been made, advise all previous recipients of the record to whom disclosure of such was made and accounted for, of the fact that the amendment was made and the substance of the amendment.

(j) *Disclosure of record to person other than the individual to whom it pertains.* (1) Records collected and maintained by the Railroad Retirement Board in the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act which contain information of a personal or private nature shall not be disclosed to any person or to another agency without the express written consent of the individual to whom the record pertains. Such written consent shall not be required if the disclosure is not otherwise prohibited by law or regulation and is:

(i) To officers or employees of the Railroad Retirement Board who, in the performance of their official duties, have a need for the record;

(ii) Required under section 552 of title 5 of the U.S. Code;

(iii) For a routine use of such record as published in the annual notice in the FEDERAL REGISTER;

(iv) To the Bureau of the Census for uses pursuant to the provisions of title 13 of the United States Code;

(v) To a recipient who has provided the Board with advance written assurance that the record will be used solely as a statistical or research record, and the record is to be transferred in a form that is not individually identifiable;

(vi) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the U.S. Government or for evaluation by the administrator of General Services or his designee to determine whether the record has such value;

(vii) To another agency or to an instrumentality of any governmental jurisidiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of the agency or instrumentality has made a written request to the agency which maintains the record specifying the particular portion desired and the law enforcement activity for which the record is sought;

(viii) To a person pursuant to a showing of compelling circumstances affecting the health or safety of an individual if, upon such disclosure, notification is transmitted to the last known address of such individual;

(ix) To either House of Congress, or, to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee;

(x) To the Comptroller General, or any of his authorized representatives, in the course of the performance of the duties of the General Accounting Office; or

(xi) Pursuant to the order of a court of competent jurisdiction.

(2) The Railroad Retirement Board shall maintain an accounting of all disclosures of records made under paragraph (h)(1) of this section, except those made under paragraphs (h)(1)(i) and (ii) of this section. This accounting will include:

(i) Date of disclosure;

(ii) Specific subject matter of disclosure;

(iii) Purpose of disclosure; and

(iv) Name and address of the person or agency to whom the information has been released.

The Railroad Retirement Board shall maintain the accounting for five years or the life of the system of records, whichever is longer, and make such accounting, with the exception of disclosures made under paragraph (h)(1)(vii) of this section, available to the individual to whom the record pertains upon his request. If, subsequent to disclosure of a record for which disclosure an accounting has been made pursuant to this subsection, an amendment is made to that record or an individual has filed a statement of disagreement concerning that record, the person or agency to whom such disclosure was made shall be notified of the amendment or statement of disagreement.

(k) *Annual notice of systems of records.* The Railroad Retirement Board shall publish in the FEDERAL REGISTER on an annual basis a listing of the various systems of records which it maintains by individual identifier. That notice shall provide the following for each system:

(1) The name and location of the system;

(2) The categories of individuals on whom records are maintained in the system;

(3) The routine uses of the system;

(4) The methods of storage, disposal, retention, access controls and retrievability of the system;

(5) The title and business address of the individual who is responsible for the system;

(6) The procedure whereby an individual can be notified at his request whether or not the system contains a record pertaining to him;

(7) The procedure whereby the individual can be notified at his request how he can gain access to any record pertaining to him which is contained in the system;

(8) How the individual can contest the contents of such a record; and

(9) The categories of sources of records in the system.

(l) *Collection of information and maintenance of records.* With respect to each system of records indexed by individual identifer which is maintained by the

Railroad Retirement Board, the Railroad Retirement Board shall:

(1) Maintain in each system only such information about an individual as is relevant and necessary in accomplishing the purposes for which the system is kept;

(2) To the greatest extent practicable, collect information directly from the individual when that information may result in an adverse determination about such individual's rights, benefits or privileges under programs administered by the Railroad Retirement Board;

(3) Inform each individual who is asked to supply information:

(i) The authority under which the solicitation of such information is carried out;

(ii) Whether disclosure of the requested information is mandatory or voluntary and any penalties for failure to furnish such information;

(iii) The principal purposes for which the information will be used;

(iv) The routine uses and transfers of such information; and

(v) The possible effects on such individual if he fails to provide the requested information.

(4) Maintain all records which are used by the Railroad Retirement Board in making any determination about any individual with such accuracy, relevance, timeliness and completeness as is reasonably necessary to assure fairness to the individual in the determination;

(5) Prior to disseminating any record about an individual to any person other than an agency, unless the dissemination is made pursuant to paragraph (h)(1)(ii) of this section, make reasonable efforts to assure that such records are accurate, complete, timely and relevant for purposes of the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act;

(6) Maintain no record describing how any individual exercises rights guaranteed by the First Amendment unless expressly authorized by statute or by the individual to whom the record pertains or unless pertinent to and within the scope of an authorized law enforcement activity;

(7) Make reasonable efforts to serve notice on an individual when any record on such individual is made available to any person under compulsory legal process when such process becomes a matter of public record; and

(8) At least thirty days prior to publication of information under paragraph (i) of this section, publish in the FEDERAL REGISTER notice of any new use or intended use of the information in the system and provide an opportunity for interested persons to submit written data, views or arguments to the Railroad Retirement Board.

(m) *Fees.* The Railroad Retirement Board may assess a fee for copies of any records furnished to an individual under paragraph (d) of this section. The fees for copies shall be $.10 per copy per page, not to exceed the actual cost of reproduction, and should be paid to the Director of Budget and Fiscal Operations for deposit to the Railroad Retirement Account. If payment is made by check, the check should be payable to the order of the Railroad Retirement Board. Any fee of less than $10 may be waived by the system manager if he determines that it is in the public interest to do so.

(n) *Government contractors.* When the Railroad Retirement Board provides by a contract or by a subcontract subject to its approval for the operation by or on behalf of the Railroad Retirement Board of a system of records to accomplish an agency function, the Railroad Retirement Board shall, consistent with its authority, cause the requirements of section 552a of title 5 of the United States Code to be applied to such system. In each such contract or subcontract for the operation of a system of records, entered into on or after September 27, 1975, the Railroad Retirement Board shall cause to be included a provision stating that the contractors or subcontractors and their employees shall be considered employees of the Railroad Retirement Board for purposes of the civil and criminal penalties provided in sections (g) and (i) of the Privacy Act of 1974 (5 U.S.C. 552a (g) and (i)).

(o) *Mailing lists.* The Railroad Retirement Board shall neither sell nor rent

information containing any individual's name or address, unless authorized by statute.

(p) *Disclosure of social security account numbers.* Whenever an individual is requested by the Railroad Retirement Board to disclose his social security account number he shall be informed as to whether such disclosure is mandatory or voluntary. If disclosure of the individual's social security account number is mandatory, he shall be informed of the statutory authority requiring such disclosure.

[41 FR 20580, May 19, 1976, as amended at 43 FR 17468, Apr. 25, 1978; 50 FR 27222, July 2, 1985. Redesignated at 52 FR 11010, Apr. 6, 1987, as amended at 53 FR 3198, Feb. 4, 1988; 54 FR 43055, Oct. 20, 1989]

§ 200.6 Open meetings.

(a) *Definitions*—(1) *Meeting.* For purposes of this section, the term ''meeting'' shall mean the deliberations of at least two of the three members of the Railroad Retirement Board, which deliberations determine or result in the joint conduct or disposition of official agency business. The term ''meeting'' shall not include:

(i) Deliberations of the Board members concerning the closure of a meeting, the withholding of any information with respect to a meeting, the scheduling of a meeting, the establishment of the agenda of a meeting, or any change in the scheduling, agenda, or the open or closed status of a meeting; or

(ii) Consideration by the Board members of agency business circulated to them individually in writing for disposition by notation.

(2) *Public announcement.* For purposes of this section the term ''public announcement'' shall mean the posting of the notice of a scheduled meeting as required by this section on a bulletin board available to the public on the first floor of the Board's headquarters building located at 844 Rush Street, Chicago, Illinois 60611.

(b)(1) The members of the Board shall not jointly conduct or dispose of agency business except in accordance with the procedures and requirements established by this section. *Provided, however,* That nothing in this section shall be construed so as to prohibit the Board from disposing of routine or administrative matters by sequential, notational voting.

(2) Where agency business is disposed of by notational voting as provided in paragraph (b)(1) of this section, the minutes of the next succeeding Board meeting shall reflect such action.

(3) Every portion of every meeting of the Board at which agency business is conducted or disposed of shall be open to public observation, except as provided in paragraph (c) of this section.

(c)(1) Except as provided in this section, every portion of every meeting of the Board shall be open to the public. A meeting or a portion of a meeting may be closed where (i) the Board properly determines that the subject matter of the meeting or portion thereof is such as to make it likely that disclosure of matters falling within one or more of the exceptions set out in paragraph (c)(3) of this section would result, and (ii) the Board determines that the public interest would not require that the meeting or portion thereof be open to the public.

(2) The requirements of paragraphs (d) and (e) of this section shall not apply to information pertaining to a meeting which would otherwise be required to be disclosed to the public under this section where the Board properly determines that the disclosure of the information is likely to disclose matters within the exceptions listed in paragraph (c)(3) of this section, and that the public interest would not require that the matters, even though excepted, should be disclosed.

(3) The Board may close a meeting or a portion thereof and may withhold information concerning the meeting or portion thereof, including the explanation of closure, the description of the subject matter of the meeting, and the list of individuals expected to attend, which otherwise would be required to be made public under paragraphs (d) and (e) of this section, where it has determined, as provided in paragraphs (c)(1) and (2) of this section, where it has determined, as provided in paragraphs (c)(1) and (2) of this section, that the public interest would not otherwise require that the meeting or portion thereof be open or that the information be made public, and that the

meeting, or portion thereof, or the disclosure of the information is likely to:

(i) Disclose matters that are (A) specifically authorized under criteria established by Executive Order to be kept secret in the interests of national defense or foreign policy and (B) in fact properly classified pursuant to such executive order;

(ii) Relate solely to the internal personnel rules and practices of the Board;

(iii) Disclose matters exempted from disclosure under 45 U.S.C. 362(d) and 362(n) and 45 U.S.C. 231f(b)(3) or disclose matters specifically exempted from disclosure by any other statute (other than 5 U.S.C 552), *Provided,* That such other statute either requires that the matters be withheld from the public in such a manner as to afford no discretion on the issue or establishes particular criteria for withholding or refers to particular types of matters to be withheld;

(iv) Disclose trade secrets and commercial or financial information obtained from a person and privileged or confidential;

(v) Involve accusing any person of a crime, or formally censuring any person;

(vi) Disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(vii) Disclose investigatory records compiled for law enforcement purposes, or information which if written would be contained in such records, but only to the extent that the production of such records or information would

(A) Interfere with law enforcement proceedings,

(B) Deprive a person of a right to a fair trial or an impartial adjudication,

(C) Constitute an unwarranted invasion of personal privacy,

(D) Disclose the identity of a confidential source and, in the case of a record compiled by a criminal law enforcement authority in the course of a criminal investigation, or by an agency conducting a lawful national security intelligence investigation, confidential information furnished only by the confidential source,

(E) Disclose investigative techniques and procedures, or

(F) Endanger the life or physical safety of law enforcement personnel;

(viii) Disclose information the premature disclosure of which would be likely to significantly frustrate implementation of a proposed Board action, except that this paragraph shall not apply in any instance where the Board has already disclosed to the public the content or nature of its proposed action, or where the Board is required by law to make such disclosure on its own initiative prior to taking final agency action on such proposal; or

(ix) Specifically concern the agency's issuance of a subpoena, or the agency's participation in a civil action or proceeding, an action in a foreign court or international tribunal, or an arbitration, or the initiation, conduct, or disposition by the agency of a particular case of formal agency adjudication pursuant to the authority granted in 45 U.S.C. 231f and 45 U.S.C. 365.

(d)(1) Any action by the Board to close a meeting or a portion thereof, or to withhold any information pertaining to such meeting or portion thereof, shall be taken only upon the vote of at least two members of the Board that the meeting or portion thereof be closed or information withheld for one or more of the reasons set forth in paragraph (c)(3) of this section. A single vote may be taken with respect to a series of meetings, to close the meetings or portions thereof or to withhold information pertaining to such meetings, where the meetings or portions thereof involve the same subject matter and are scheduled within 30 calendar days after the date of the initial meeting in the series.

(2) The vote of each member of the Board participating in the vote on closure of a meeting or portion thereof shall be recorded. Vote by proxy shall not be allowed.

(3) A person whose interests might be directly affected by a meeting or portion thereof which otherwise would be open may request that the meeting or portion thereof which concerns such person's interests be closed under paragraphs (c)(3)(v), (vi), or (vii) of this section. The request should be directed to The Secretary, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611, and must be received no

later than the beginning of the meeting to which it applies. Upon receipt of such a request the Board shall vote by recorded vote on the question as to whether the meeting or portion thereof should be closed.

(4) Within one day following a vote taken under paragraphs (d)(2) and (3) of this section, a copy of such vote showing the vote of each member shall be available for public inspection and copying in the office of the Secretary of the Board, located in the Board's headquarters office.

(5) If a meeting or portion thereof is closed in accordance with an action under paragraphs (d)(2) or (3) of this section, the Board shall, within one day following the vote, except to the extent such information is exempt from disclosure under paragraph (c) of this section, make available for inspection and copying in the office of the Secretary of the Board a written explanation of the Board's action and a list of the persons expected to attend and their affiliations.

(e)(1) Except as to those meetings or portions of meetings scheduled as provided in paragraphs (d)(2) and (3) of this section, the Board shall for each meeting make public announcement at least one week prior thereto of the time, place and subject matter of the meeting, whether the meeting is to be open or closed to the public, and the name and telephone number of an official of the Railroad Retirement Board designated by the Board to respond to any requests from the public pertaining to the meeting.

(2) The requirement contained in paragraph (e)(1) of this section that the Board give one week advance notice of each meeting shall not apply where the Board determines by majority vote, which vote shall be recorded, that agency business requires that a meeting be scheduled at an earlier date. If a meeting is scheduled less than one week in the future, as provided in this paragraph, the Board shall make a public announcement at the earliest practicable time of the time, place and subject matter of the meeting and whether the meeting is to be open or closed to the public.

(3) The Board may change the time and place of a previously scheduled and announced meeting, but such change must be announced to the public at the earliest practicable time. The Board may change the subject matter, or its determination to open or close a meeting or portion thereof, of a previously scheduled and announced meeting only if (i) a majority of the Board determines by recorded vote that agency business requires the change and that no earlier public announcement of the change was possible, and (ii) the Board makes a public announcement of the change and the vote of each member thereon at the earliest practicable time.

(4) Immediately following each public announcement required by this subsection, the Board shall submit for publication in the FEDERAL REGISTER notice of the time, place, and subject matter of the meeting, whether the meeting is to be open or closed, any changes in such items from a previous announcement, and the name and telephone number of the Railroad Retirement Board official designated by the Board to respond to requests concerning the announced meeting.

(f)(1) Whenever the Board should determine to close a meeting or a portion of a meeting under any of the exemptions contained in paragraph (c)(3) of this section, the General Counsel of the Railroad Retirement Board shall, prior to the meeting, certify in writing that in his or her opinion the meeting or portion thereof may be closed to the public and shall state the applicable exemptions which permit closure. The Board shall maintain a copy of the General Counsel's certification and a copy of the statement of the presiding officer of the meeting setting forth the time and place of the meeting and a list of the persons present, other than those present merely as spectators.

(2) In the event that a meeting or any portion of a meeting is closed to the public, a complete transcript or recording shall be made of the meeting or portion thereof closed; *Provided, however*, That if the meeting or portion thereof is closed under paragraph (c)(3)(ix) of this section, a set of minutes may be made of the closed meeting or portion of a meeting in lieu of a complete transcript or recording thereof. If a set of minutes is the method

chosen to record the proceedings of a meeting or portion thereof closed under paragraph (c)(3)(ix) of this section, such minutes shall fully and clearly describe the matters discussed. The minutes shall also fully reflect any actions taken by the Board, set forth a statement of the reasons for such actions, summarize each of the views expressed concerning such actions, identify any documents considered in connection with such agency actions, and show the vote of the Board and each of its members on such actions.

(3) The transcript, recording, or minutes of each meeting or portion thereof closed to the public shall be available for public inspection or listening in the office of the Secretary of the Board, 844 Rush Street, Chicago, Illinois 60611, no later than two weeks following the meeting. There shall be expunged or erased from the transcript, recording, or minutes of each meeting which is made available to the public any items of discussion or testimony when it has been determined that they contain information which may be withheld under paragraph (c) of this section, and that the public interest would not require disclosure. The determination as to what items of discussion or testimony shall be expunged or erased from the copies of the transcript, recording, or minutes available to the public shall be made by the Secretary of the Board with the approval of the Board.

(4) Copies of transcripts, minutes, or transcriptions of recordings maintained by the Board as provided in paragraph (e)(3) of this section shall be provided to members of the public who request such copies, at the actual cost of duplicating or transcription. Requests for copies of transcripts, minutes or transcriptions of recordings should be in writing, addressed to the Secretary of the Board, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611, and should clearly indicate the date of the meeting or meetings for which such copies are requested. If the requester desires a copy of only a portion or portions of the transcript, minutes, or transcription of a specified meeting, the request should specify which portion or portions are desired.

(5) The Board shall maintain the complete transcript, recording, or minutes required to be made under paragraph (e)(2) of this section for a period of at least two years after the meeting, or for at least one year after the conclusion of any agency proceeding with respect to which the meeting or portion of the meeting was held, whichever occurs later.

(g) Nothing in this section shall expand or limit the rights of any person under 5 U.S.C. 552, and 20 CFR 200.3, except that the exemptions contained in paragraph (c) of this section shall govern in the case of any request under 5 U.S.C. 552 and 20 CFR 200.3 to copy, inspect, or obtain copies of transcripts, recordings, or minutes described in paragraph (f) of this section. Nothing in this section shall limit the rights of any individual under 5 U.S.C. 552a and 20 CFR 200.4 to gain access to any record which would be available to such individual under those provisions.

[42 FR 15312, Mar. 21, 1977, as amended at 42 FR 22865, Nov. 11, 1977. Redesignated at 52 FR 11010, Apr. 6, 1987]

§ 200.7 Assessment or waiver of interest, penalties, and administrative costs with respect to collection of certain debts.

(a) *Purpose.* The Debt Collection Act of 1982 requires the Board to charge interest on claims for money owed the Board, to assess penalties on delinquent debts, and to assess charges to cover the costs of processing claims for delinquent debts. The Act permits, and in certain cases requires, an agency to waive the collection of interest, penalties and charges under circumstances which comply with standards enunciated jointly by the Comptroller General and the Attorney General. Those standards are contained in 4 CFR 102.13. This section contains the circumstances under which the Board may either assess or waive interest, penalties, and administrative costs which arise from benefit or annuity overpayments made under any of the Acts which the Board administers.

(b)(1) Simple interest shall be assessed once a month on the unpaid principal of a debt.

(2) Interest shall accrue from the date on which notice of the debt and

demand for repayment with interest is first mailed or hand-delivered to the debtor, or in the case of a debt which is subject to section 10(c) of the Railroad Retirement Act or section 2(d) of the Railroad Unemployment Insurance Act, interest shall accrue from the date that a denial of waiver of recovery is mailed or hand-delivered to the debtor or, if waiver has not been requested, upon the expiration of the time within which to request waiver, except as otherwise specified in this section.

(3) In the case of a lien for reimbursement of sickness benefits pursuant to part 341 of this chapter, interest on the amount of the lien shall accrue from the date of settlement or the entry of final judgment.

(4) The rate of interest assessed shall be the rate of the current value of funds to the U.S. Treasury (i.e., the Treasury tax and loan account rate) as prescribed and published in the FEDERAL REGISTER and the Treasury Financial Manual Bulletins annually or quarterly, in accordance with 31 U.S.C. 3717.

(5) The rate of interest as initially assessed shall remain fixed for the duration of the indebtedness, except that where a debtor has defaulted on a repayment agreement and seeks to enter into a new agreement, a new interest rate may be assessed.

(c)(1) A penalty charge of 6 percent per year shall be assessed on any debt that is delinquent for more than 90 days.

(2) The penalty charge shall accrue from the date on which the debt became delinquent.

(3) A debt is delinquent if it has not been paid in full by the 30th day after the date on which the initial demand letter was first mailed or hand-delivered, or, if the debt is being repaid under an installment payment agreement, at any time after the debtor fails to satisfy his or her obligation for payment thereunder.

(4) In the case of a lien for reimbursement of sickness benefits pursuant to part 341 of this chapter, the amount of the lien is delinquent if it has not been paid in full by the 30th day after the date of settlement or entry of final judgment.

(d)(1) Charges shall be assessed against the debtor for administrative costs incurred as a result of processing and handling the debt because it became delinquent.

(2) Administrative costs include costs incurred in obtaining a credit report and in using a private debt collector.

(e) When a debt is paid in partial or installment payments, amounts received shall be applied first to outstanding penalty and administrative cost charges, second to accrued interest, and third to outstanding principal. Where a debtor is in default under an installment repayment agreement, uncollected interest, penalties and administrative cost charges which have accrued under the agreement shall be added to the principal to be paid under any new installment repayment agreement entered into between the Board and the debtor.

(f) *Exemptions.* The assessment of interest, penalties, and administrative costs under this section does not apply to debts under sections 2(f) and 8(g) of the Railroad Unemployment Insurance Act (45 U.S.C. 352(f) and 358(g)).

(g)(1) The Board shall waive the collection of interest under the following circumstances:

(i) When the debt is paid within thirty days after the date on which notice of the debt was mailed or personally delivered to the debtor,

(ii) When, in any case where a decision with respect to waiver of recovery of an overpayment must be made:

(A) The debt is paid within thirty days after the end of the period within which the debtor may request waiver of recovery, if no request for waiver is received within the prescribed time period; or

(B) The debt is paid within thirty days after the date on which notice was mailed to the debtor that his or her request for waiver of recovery has been wholly or partially denied if the debtor requested waiver of recovery within the prescribed time limit; however, regardless of when the debt is paid, no interest may be charged for any period prior to the end of the period within which the debtor may request waiver of recovery or, if such request is made, for any period prior to the date on which notice was mailed to the debtor that

his or her request for waiver of recovery has been wholly or partially denied;

(iii) When, in the situations described in paragraphs (g)(1)(i) and (ii) of this section, the debt is paid within any extension of the thirty-day period granted by the Board;

(iv) With respect to any portion of the debt which is paid within the time limits described in paragraphs (g)(1)(i), (g)(1)(ii), or (g)(1)(iii) of this section; or

(v) In regard to any debt the recovery of which is waived.

(2) The Board may waive the collection of interest, penalties and administrative costs in whole or in part in the following circumstances:

(i) Where, in the judgment of the Board, collecting interest, penalty and administrative costs would be against equity and good conscience; or

(ii) Where, in the judgment of the Board, collecting interest, penalty and administrative costs would not be in the best interest of the United States.

(h)(1) In making determinations as to when the collection of interest, penalty and administrative costs is against equity and good conscience the Board will consider evidence on the following factors:

(i) The fault of the overpaid individual in causing the underlying overpayment; and

(ii) Whether the overpaid individual in reliance on the incorrect payment relinquished a valuable right or changed his or her position for the worse.

(2) In rendering a determination as to when the collection of interest, penalties and administrative costs is not in the best interest of the United States the Board will consider the following factors:

(i) Whether the collection of interest, penalties and administrative costs would result in the debt never being repaid; and

(ii) Whether the collection of interest, penalties and administrative costs would cause undue hardship.

(i) The Board shall waive the collection of interest, penalties, and administrative costs in any case where the debt to be recovered is being recovered by full or partial withholding of a current annuity payable under the Railroad Retirement Act and the debt was not incurred through fraud.

[52 FR 41559, Oct. 29, 1987, as amended at 59 FR 15049, Mar. 31, 1994; 67 FR 5723, Feb. 7, 2002]

§ 200.8 Disclosure of information obtained in the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(a) *Purpose and scope.* The purpose of this section is to establish specific procedures necessary for compliance with section 12(d) of the Railroad Unemployment Insurance Act, which is incorporated into the Railroad Retirement Act by section 7(b)(3) of that Act. Except as otherwise indicated in this section, these regulations apply to all information obtained by the Railroad Retirement Board in connection with the administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(b) *Definitions—Agency.* The term *agency* refers to the Railroad Retirement Board, an independent agency in the executive branch of the United States Government.

Applicant. The term *applicant* means a person who signs an application for an annuity or lump-sum payment or unemployment benefits or sickness benefits for himself or herself or for some other person.

Beneficiary. The term *beneficiary* refers to an individual to whom a benefit is payable under either the Railroad Retirement Act or the Railroad Unemployment Insurance Act.

Board. The term *Board* refers to the three-member governing body of the Railroad Retirement Board.

Document. The term *document* includes correspondence, applications, claims, reports, records, memoranda and any other materials or data used, prepared, received or transmitted to, from, by or for the agency in connection with the administration of the Railroad Retirement Act or the Railroad Unemployment Insurance Act.

Information. The term *information* means any non-medical document or data which is obtained by the agency in the administration of the Railroad Retirement Act and/or the Railroad

Unemployment Insurance Act. *Information* does not include the fact of entitlement to or the amount of a benefit under either of these Acts. Medical records are subject to the disclosure provisions set out in § 200.5(e) of this part.

Testify and testimony. The terms *testify* and *testimony* include both in-person oral statements before a court or a legislative or administrative body and statements made in the form of depositions, interrogatories, declarations, affidavits or other means of formal participation in such proceedings.

(c) *General rule.* Except as otherwise authorized by this section, information shall not be produced, disclosed, delivered or open to inspection in any manner revealing the identity of an employee, applicant or beneficiary unless the Board or its authorized designee finds that such production, disclosure, delivery, or inspection is clearly in furtherance of the interest of the employee, applicant or beneficiary or of the estate of such employee, applicant, or beneficiary. Where no such finding is made, no information shall be released except in accordance with the provisions of § 200.5 of this part, unless release of such information is required by a law determined to supersede this general rule. In addition, regardless of whether or not such finding can be made, information which is compiled in anticipation of a civil or criminal action or proceeding against an applicant or beneficiary may not be released under this general rule.

(d) *Subpoenas—statement of policy and general rule.* (1) It is the policy of the Board to provide information, data, and records to non-Federal litigants to the same extent and in the same manner that they are available to the general public. The availability of Board employees to testify before state and local courts and administrative and legislative bodies, as well as in Federal court and administrative proceedings which involve non-Federal litigants, concerning information acquired in the course of performing their official duties or because of the employee's official capacity, is governed by the Board's policy of maintaining strict impartiality with respect to private litigants and minimizing the disruption of an employee's official duties. Thus, the Board may refuse to make an employee available for testimony under this paragraph or paragraph (e) or (f) of this section if it determines that the information sought is available other than through testimony and where making such employee available would cause disruption of agency operations. However, this paragraph does not apply to any civil or criminal proceeding where the United States, the Railroad Retirement Board, or any other Federal agency is a party; to Congressional requests or subpoenas for testimony; to consultative services and technical assistance provided by the Board or the agency in carrying out its normal program activities; to employees serving as expert witnesses in connection with professional and consultative services rendered as approved outside activities (in cases where employees are providing such outside services, they must state for the record that the testimony represents their own views and does not necessarily represent the official position of the agency); or to employees making appearances in their private capacity in legal or administrative proceedings that do not relate to the official business of the agency (such as cases arising out of traffic accidents, crimes, domestic relations, etc.) and not involving professional and consultative services as described above.

(2) No officer, agent, or employee of the agency is authorized to accept or receive service of subpoenas, summons, or other judicial process addressed to the Board or to the agency except as the Board may from time to time delegate such authority by power of attorney. The Board has issued such power of attorney to the Deputy General Counsel of the agency and to no one else.

(3) In the event the production, disclosure, or delivery of any information is called for on behalf of the United States or the agency, such information shall be produced, disclosed, or delivered only upon and pursuant to the advice of the Deputy General Counsel.

(4) When any member, officer, agent, or employee of the agency is served with a subpoena to produce, disclose, deliver, or furnish any information, he

or she shall immediately notify the Deputy General Counsel of the fact of the service of such subpoena. Unless otherwise ordered by the Deputy General Counsel or his or her designee, he or she shall appear in response to the subpoena and respectfully decline to produce, disclose, deliver, or furnish the information, basing such refusal upon the authority of this section.

(e) *Subpoena duces tecum.* (1) When any document is sought from the agency by a subpoena duces tecum or other judicial order issued to the agency by a court of competent jurisdiction in a proceeding wherein such document is relevant, a copy of such document, certified by the Secretary to the Board to be a true copy, may be produced, disclosed, or delivered by the agency if, in the judgment of the Board or its designee, such production is clearly in furtherance of the interest of the employee, applicant, or beneficiary to whom the document pertains, or is clearly in furtherance of the interest of the estate of such employee, applicant, or beneficiary, and such document does not consist of or include a report of medical information.

(2) When the production, diclosure, or delivery of any document described in paragraph (e)(1) of this section would not be permitted under the standards therein set forth, no member, officer, agent, or employee of the agency shall make any disclosure of or testify with respect to such document.

(f) *Requests for voluntary testimony.* All requests for testimony by a Board employee in his or her official capacity must be in writing and directed to the Deputy General Counsel. They shall state the nature of the requested testimony, why the information is not available by any other means, and the reasons, if any, why the testimony would be in the interest of the Board or the Federal government.

(g) *Authorized release of information.* Subject to the limitation expressed in paragraph (h) of this section, disclosure of documents and information is hereby authorized, in such manner as the Board may by instructions prescribe, in the following cases:

(1) To any employer, employee, applicant, or prospective applicant for an annuity or death benefit under the Railroad Retirement Act of 1974, or his or her duly authorized representative, as to matters directly concerning such employer, employee, applicant, or prospective applicant in connection with the administration of such Act.

(2) To any employer, employee, applicant or prospective applicant for benefits under the Railroad Unemployment Insurance Act, or his or her duly authorized representative, as to matters directly concerning such employer, employee, applicant, or prospective applicant in connection with the administration of such Act.

(3) To any officer or employee of the United States lawfully charged with the administration of the Railroad Retirement Tax Act, the Social Security Act, or acts or executive orders administered by the Department of Veterans Affairs, and for the purpose of the administration of those Acts only.

(4) To any applicant or prospective applicant for death benefits or accrued annuities under the Railroad Retirement Act, or to his or her duly authorized representative, as to the amount payable as such death benefits or accrued annuities, and the name of the person or persons determined by the agency to be the beneficiary, or beneficiaries, thereof, if such applicant or prospective applicant purports to have a valid reason for believing himself or herself to be, in whole or in part, the beneficiary thereof.

(5) To any officer or employee of the United States lawfully charged with the administration of any Federal law concerning taxes imposed with respect to amounts payable under the Railroad Retirement Act of 1974 and the Railroad Unemployment Insurance Act and the name of the person or persons to whom such amount was payable.

(6) To any officer or employee of any state of the United States lawfully charged with the administration of any law of such state concerning unemployment compensation, as to the amounts payable to payees or beneficiaries under the Railroad Retirement Act of 1974 and the Railroad Unemployment Insurance Act.

(7) To any court of competent jurisdiction in which proceedings are pending which relate to the care of the person or estate of an incompetent individual, as to amounts payable under the Railroad Retirement Act to such incompetent individual, but only for the purpose of such proceedings.

(8) To parties involved in litigation, including an action with respect to child support, alimony, or marital property, the amount of any actual or estimated benefit payable under the Railroad Retirement Act or the Railroad Unemployment Insurance Act, where such amount or estimated amount is relevant to that litigation.

(9) To any employer, as to the monthly amount of any retirement annuity under the Railroad Retirement Act of 1974 or benefit under the Railroad Unemployment Insurance Act to which a present or former employee of that employer is entitled.

(10) To any governmental welfare agency, information about the receipt of benefits and eligibility for benefits.

(11) To any law enforcement agency, information necessary to investigate or prosecute criminal activity in connection with claims for benefits under the Railroad Retirement Act, Railroad Unemployment Insurance Act, or any other Act the Board may be authorized to administer.

(12) To any consular official, other than a consular officer of a country to which United States Treasury checks and warrants may not be sent, acting in behalf of a compatriot who has claimed benefits under the Railroad Retirement Act or Railroad Unemployment Insurance Act, information that is pertinent to the claim and that the applicant himself could have upon his or her own request.

(h) No document and no information acquired solely by reason of any agreement, arrangement, contract, or request by or on behalf of the agency, relating to the gathering, preparation, receipt or transmittal of documents or information to, from or for the agency, which is by virtue of such agreement, arrangement, contract, or request in the possession of any person other than an employee of the agency, shall be produced, reproduced, or duplicated, disclosed or delivered by any person to any other person or tribunal (other than the agency or an employee thereof, or the person to whom the document or information pertains), whether in response to a subpoena or otherwise, except with the consent of the Board or its designee. Any person, upon receipt of any request, subpoena, or order calling for the production, disclosure, or delivery of such document or information shall notify the Board or its designee of the request, subpoena, or order and shall take no further action except upon advice of the Board or its designee. Unless consent of the Board or its designee is given, the person shall respectfully decline to comply with the request, subpoena or order.

(i) Notwithstanding any other provision of this section, no disclosure of information may be made by the Board or any member, officer, agent, or employee of the agency, if the disclosure of such information is prohibited by law.

(j) The Deputy General Counsel or his designee will request the assistance of the Department of Justice where necessary to represent the interests of the agency and its employees under this section.

[54 FR 43055, Oct. 20, 1989, as amended at 56 FR 50247, Oct. 4, 1991; 63 FR 2141, Jan. 14, 1998]

§ 200.9 Selection of members of Actuarial Advisory Committee.

(a) *Introduction.* Under section 15(f) of the Railroad Retirement Act of 1974 (45 U.S.C. 231n(f)), the Board is directed to select two actuaries to serve on an Actuarial Advisory Committee. This section describes how the two actuaries are selected.

(b) *Carrier actuary.* One member of the Actuarial Advisory Committee shall be selected by recommendations made by ''carrier representatives.'' ''Carrier representatives,'' as used in this section, shall mean any organization formed jointly by the express companies, sleeping-car companies and carriers by railroad subject to the Interstate Commerce Act which own or control more than 50 percent of the total railroad mileage within the United States.

(c) *Railway labor actuary.* The other member of the Actuarial Advisory

Committee to be selected by the Board shall be recommended by ''representatives of employees.'' ''Representatives of employees,'' as used in this section, shall mean any organization or body formed jointly by a majority of railway labor organizations organized in accordance with the provisions of the Railway Labor Act, as amended, or any individual or committee authorized by a majority of such railway labor organizations to make such recommendation.

[54 FR 43056, Oct. 20, 1989]

§ 200.10 Representatives of applicant or beneficiaries.

(a) *Power of attorney.* An applicant or a beneficiary shall not be required to hire, retain or utilize the services of an attorney, agent, or other representative in any claim filed with the Board. In the event an applicant or beneficiary desires to be represented by another person, he or she shall file with the Board prior to the time of such representation a power of attorney signed by such applicant or beneficiary and naming such other person as the person authorized to represent the applicant or beneficiary with respect to matters in connection with his or her claim. However, the Board may recognize one of the following persons as the duly authorized representative of the applicant or beneficiary without requiring such power of attorney when it appears that such recognition is in the interest of the applicant or beneficiary:

(1) A Member of Congress;

(2) A person designated by the railway labor organization of which the applicant or beneficiary is a member to act on behalf of members of that organization on such matters; or

(3) An attorney who, in the absence of information to the contrary, declares that he or she is representing the applicant or beneficiary.

(b) *Payment of claim.* The Board will not certify payment of any awarded claim to or through any person other than the applicant or beneficiary for the reason that a power of attorney for such person to represent such applicant or beneficiary has been filed.

[54 FR 43057, Oct. 20, 1989]

SUBCHAPTER B—REGULATIONS UNDER THE RAILROAD RETIREMENT ACT

PART 201—DEFINITIONS

AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314, as amended; 45 U.S.C. 228a, 228j.

§ 201.1 Words and phrases.

For the purposes of the regulations in this chapter, except where the language or context indicates otherwise:

(a) *Act*. The term ''act,'' or ''1937 act'' means the Railroad Retirement Act of 1937 (50 Stat. 307; 45 U.S.C. chapter 9). The term ''1935 act,'' means the Railroad Retirement Act of 1935 (49 Stat. 967; 45 U.S.C. chapter 9).

(b) *Employer*. The term ''employer'' means an employer as defined in the act and part 202 of this chapter.

(c) *Employee*. The term ''employee'' means an employee as defined in the act and part 203 of this chapter.

(d) *Service*. The term ''service'' means service as defined in the act and part 220 of this chapter.

(e) *Compensation*. The term ''compensation'' means compensation as defined in the act and part 222 of this chapter.

(f) *Board*. The term ''Board'' means the Railroad Retirement Board.

(g) *Company*. The term ''company'' means a partnership, association, joint stock company, corporation, or institution.

(h) *United States*. The term ''United States'' where used in a geographical sense means the States and the District of Columbia.

(i) *Carrier*. The term ''carrier'' means an express company, sleeping-car company, or carrier by railroad, subject to part I of the Interstate Commerce Act (24 Stat. 379; 49 U.S.C. chapter 1).

(j) *Person*. The term ''person'' includes an individual, trust, estate, partnership, association, joint stock company, company, corporation, and institution.

(k) *General Committee*. The term ''General Committee'' as used in section 1 of the Railroad Retirement Act of 1937 (50 Stat. 307; 45 U.S.C., Sup., 228a) is construed to include any subordinate unit of a national railway labor organization, defined as an employer in the 1937 act, regardless of the title or designation of such unit, which, under the constitution and bylaws of the organization of which it is a unit, is properly authorized to and does represent that organization on all of a particular railroad or on a substantial portion thereof (such as on that portion of a railroad under the jurisdiction of the general manager) in negotiating with the management of that railroad with respect to the wages and working conditions of the employees represented by such organization.

(l) *Local lodges and divisions; local lodge or division*. The term ''local lodges and divisions'' and the term ''local lodge or division'' as used in section 1(a) and 1(b), respectively, of the 1937 act, shall be construed to include any subordinate unit of a national railway labor organization defined as an ''employer'' under the 1937 act, which unit functions in the same manner as, or similar to ''local lodges'' as that term is ordinarily used, irrespective of the designation of such unit by its national organization.

[4 FR 1477, Apr. 7, 1939, as amended by Board Order 40–367, 5 FR 2717, Aug. 1, 1940; Board Order 59–190, 24 FR 9083, Nov. 7, 1959]

PART 202—EMPLOYERS UNDER THE ACT

Sec.

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AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314, as amended; 45 U.S.C. 228a, 228j, unless otherwise noted.

SOURCE: 4 FR 1478, Apr. 7, 1939, unless otherwise noted.

§ 202.1 Statutory provisions.

The term ''employer'' means any carrier (as defined in subsection 1(m) of this section), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer: *Provided, however*, That the term ''employer'' shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system now or hereafter operated by any other motive power. The Interstate Commerce Commission is hereby authorized and directed upon request of the Board, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this proviso. The term ''employer'' shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and by-laws of such organizations. (Sec. 1 (a), 50 Stat. 307; 45 U. S. C. 228a (a))

The term ''employer'' shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefore, or in any of such activities. (54 Stat. 785; 45 U.S.C. 228a (a))

[4 FR 1478, Apr. 7, 1939, as amended by Board Order 41–526, 7 FR 96, Jan. 6, 1942]

§ 202.2 Company or person principally engaged in carrier business.

Any company or person principally engaged in carrier business is an employer.

§ 202.3 Company or person principally engaged in non-carrier business.

(a) With respect to any company or person principally engaged in business other than carrier business, but which, in addition to such principal business, engages in some carrier business, the Board will require submission of information pertaining to the history and all operations of such company or person with a view to determining whether some identifiable and separable enterprise conducted by the person or company is to be considered to be the employer. The determination will be made in the light of considerations such as the following:

(1) The primary purpose of the company or person on and since the date it was established;

(2) The functional dominance or subservience of its carrier business in relation to its non-carrier business;

(3) The amount of its carrier business and the ratio of such business to its entire business;

(4) Whether its carrier business is a separate and distinct enterprise.

(b) In the event that the employer is found to be an aggregate of persons or legal entities or less than the whole of a legal entity or a person operating in only one of several capacities, then the unit or units competent to assume legal obligations shall be responsible for the discharge of the duties of the employer.

§ 202.4 Control.

A company or person is controlled by one or more carriers, whenever there exists in one or more such carriers the right or power by any means, method or circumstance, irrespective of stock ownership to direct, either directly or indirectly, the policies and business of such a company or person and in any case in which a carrier is in fact exercising direction of the policies and business of such a company or person.

§ 202.5 Company or person under common control.

A company or person is under common control with a carrier, whenever the control (as the term is used in § 202.4) of such company or person is in the same person, persons, or company as that by which such carrier is controlled.

§ 202.6 Casual service and the casual operation of equipment or facilities.

The service rendered or the operation of equipment or facilities by a controlled company or person in connection with the transportation of passengers or property by railroad is ''casual'' whenever such service or operation is so irregular or infrequent as to afford no substantial basis for an inference that such service or operation will be repeated, or whenever such service or operation is insubstantial.

§ 202.7 Service or operation in connection with railroad transportation.

The service rendered or the operation of equipment or facilities by persons or companies owned or controlled by or under common control with a carrier is in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, if such service or operation is reasonably directly related, functionally or economically, to the performance of obligations which a company or person or companies or persons have undertaken as a common carrier by railroad, or to the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad.

§ 202.8 Controlled company or person principally engaged in service or operation in connection with railroad transportation.

Any company or person owned or controlled by one or more carriers or under common control therewith, whose principal business is the operation of equipment or facilities or the performance of service (other than trucking service) in connection with the transportation of passengers or property by railroad, shall be an employer.

§ 202.9 Controlled company or person not principally engaged in service or operation in connection with railroad transportation.

(a) With respect to any company or person owned or controlled by one or more carriers or under common control therewith, performing a service or operating equipment in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, but which is principally engaged in some other business, the Board will require the submission of information pertaining to the history and all operations of such company or person with a view to determining whether it is an employer or whether some identifiable and separable enterprise conducted by the person or company is to be considered to be the employer, and will make a determination in the light of considerations such as the following:

(1) The primary purpose of the company or person on and since the date it was established;

(2) The functional dominance or subservience of its business which constitutes a service or operation of equipment or facilities in connection with the transportation of passengers or property by railroad in relation to its other business;

(3) The amount of its business which constitutes a service or operation of equipment or facilities in connection with the transportation of passengers or property by railroad and the ratio of such business to its entire business;

(4) Whether such service or operation is a separate and distinct enterprise;

(5) Whether such service or operation is more than casual, as that term is defined in § 202.6.

(b) In the event that the employer is found to be an aggregate of persons or legal entities or less than the whole of a legal entity or a person operating in only one of several capacities, then the unit or units competent to assume legal obligations shall be responsible for the discharge of the duties of the employer.

§ 202.10 Commencement of employer status of receiver or trustee, etc.

A receiver, trustee, or other individual or body, judicial or otherwise, in the possession of the property or operating all or any part of the business of a carrier, or of a company or person owned or controlled by or under common control with such a carrier, which operates any equipment or facility or performs any service in connection with the transportation of passengers or property by railroad, shall be deemed to be an employer beginning as of whichever of the following three dates is the earliest:

(a) The date that it takes possession of such property; or

(b) The first date on which it has authority to operate all or any part of the business of such a carrier, company or person; or

(c) The date that it begins operating without appointment or authorization all or any part of the business of such a carrier, company or person;

Provided, however, That the receiver, trustee, or other individual or body, judicial or otherwise, shall be an employer only with respect to such individuals as would be employees if the preceding employer had continued in the possession of the property or the operation of the business.

§ 202.11 Termination of employer status.

The employer status of any company or person shall terminate whenever such company or person loses any of the characteristics essential to the existence of an employer status.

[Board Order 41–85, 6 FR 1210, Mar. 1, 1941]

§ 202.12 Evidence of termination of employer status.

(a) In determining whether a cessation of an essential characteristic, such as control or service in connection with railroad transportation, has occurred, consideration will be given only to those events or actions which evidence a final or complete cessation. Mere temporary periods of inactivity or failure to exercise functions or to operate equipment or facilities will not necessarily result in a loss of employer status.

(b) The actual date of cessation of employer status shall be the date upon which final or complete cessation of an essential employer characteristic occurs. The following indicate but do not delimit the type of evidence that will be considered in determining the actual date of cessation of an employer status: stoppage of business or operations; the cancellation of tariffs, concurrences, or powers of attorney filed with the Interstate Commerce Commission; the effective date of a certificate permitting abandonment; the effective date of a pertinent judicial action such as the discharge of a receiver, trustee, or other judicial officer, or an order approving sale of equipment or machinery; the sale, transfer, or lease of property, equipment, or machinery essential to the continuance of an employer function or to control by a carrier employer; public or private notices of contemplated or scheduled abandonment or cessation of operations; termination of contract; discharge of last employee; date upon which the right of a railway labor organization to participate in the selection of labor members of the National Railroad Adjustment Board ceases or is denied; and date on which an employer, if a labor organization, ceases to represent or is denied the right to represent crafts or classes of employees in the railroad industry, or to promote the interests of employees in the railroad industry.

(c) In the absence of evidence to the contrary the employer status of an existing company or person shall be presumed to continue, and in accordance with § 250.1(b) of this chapter it is the

duty of each employer promptly to notify the Board of any change in operations affecting such company's status as an employer.

[Board Order 41–85, 6 FR 1210, Mar. 1, 1941]

§ 202.13 Electric railways.

(a) The Deputy General Counsel will require the submission of information pertaining to the history and operations of an electric railway with a view to determining whether it is an employer and will inquire into and make his recommendations upon the following considerations:

(1) Whether the electric railway is more than a street, suburban or interurban electric railway; or

(2) Whether it is operating as a part of a general steam-railroad system of transportation; or

(3) Whether it is part of the national transportation system.

(b) If in the opinion of the Deputy General Counsel an electric railway has the characteristic set forth in either paragraphs (a)(1), (2), or (a)(3) of this section, he will conclude that it is an employer under the act and if the operator concurs in such opinion, the decision will be made final by the Board. If the operator does not concur in the conclusion reached the question will be submitted to the Interstate Commerce Commission for determination.

(45 U.S.C. 231f(b)(5))

[4 FR 1478, Apr. 7, 1939, as amended at 48 FR 51448, Nov. 9, 1983]

§ 202.14 Service incidental to railroad transportation.

An organization, association, bureau or agency is performing a service in connection with or incidental to railroad transportation whenever it is engaged in the performance of functions which would normally be performed by the constituent employers in the absence of such organization, association, bureau, or agency.

§ 202.15 Railway labor organizations.

Railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, as amended, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and bylaws of such organizations, shall be employers within the meaning of the act.

(a) An organization doing business on or after June 21, 1934, which establishes, in accordance with paragraph (a)(1), (2), or (3) of this section a right, under section 3 ''First'' (a) of the Railway Labor Act, as amended (48 Stat. 1189; 45 U.S.C. 153 ''First'' (a)), to participate in the selection of labor members of the National Railroad Adjustment Board, will be presumed, in the absence of clear and convincing evidence to the contrary, to be, from and after the date on which such right is thus established, a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended. Such an organization can establish that it is an employer by establishing, in accordance with paragraph (b) of this section, that, as a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended, it is a ''railway'' organization. An organization, doing business on or after June 21, 1934, which has not established such a right of participation, will be presumed not to be a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended, and such presumption can be rebutted only by clear and convincing evidence satisfactory to the Board showing that the reasons for the organization's failure to establish such a right have no relation to its being a labor organization, national in scope and organized in accordance with the provisions of the Railway Labor Act, as amended. Only after such presumption has thus been rebutted will further evidence as to whether the organization is an employer be considered. (The establishment or nonestablishment of such a right of participation will not raise any presumption as to whether an organization is, or is not, a ''railway'' organization. The existence of this qualification shall be determined in accordance with paragraph (b) of this section.) An

organization will have established such a right of participation if:

(1) It has in fact participated in the selection of labor members of the National Railroad Adjustment Board and has continued to participate in such selection; or

(2) It has been found, under section 3 ''First'' (f) of the Railway Labor Act, as amended (48 Stat. 1190; 45 U.S.C. 153 ''First'' (f)), to be qualified to participate in the selection of labor members of the National Railroad Adjustment Board; or

(3) It is recognized by all organizations, qualified under paragraphs (a)(1) or (2) of this section, as having the right to participate in the selection of labor members of the National Railroad Adjustment Board.

(b) The question as to whether a labor organization, national in scope, and organized in accordance with the provisions of the Railway Labor Act, as amended, is, as such a national labor organization, a ''railway'' labor organization, will be determined by the Board on the basis of considerations such as the following:

(1) The extent to which it is, and has been recognized as, representative of crafts or classes of employees in the railroad industry.

(2) The extent to which its purposes and business are and have been to promote the interests of employees in the railroad industry.

(c) A labor organization which ceased doing business before June 21, 1934, will have been an employer if its characteristics were substantially the same as those of labor organizations, doing business on or after June 21, 1934, which are established as employers in accordance with paragraphs (a) and (b) of this section.

(d) An organization which establishes, to the satisfaction of the Board, that it is a labor organization, as defined in paragraph (e) of this section, and that is composed of labor organizations which are established as employers in accordance with paragraphs (a), (b), and (c) of this section, is thereby established as being an employer.

(e) For the purposes of the regulations in this chapter, a labor organization is an organization whose business is to promote the interests of employees in their capacity as employees, either directly or through their organizations.

PART 203—EMPLOYEES UNDER THE ACT

Sec.

203.1 Statutory provisions.
203.2 General definition of employee.
203.3 When an individual is performing service for an employer.
203.4 When service is compensated.
203.5 Service outside the United States.
203.6 Age, citizenship, and other factors.
203.7 Local lodge employee.

AUTHORITY: Secs. 1, 10, 50 Stat. 307, as amended, 314 as amended; 45 U.S.C. 228a, 228j, unless otherwise noted.

SOURCE: 12 FR 1133, Feb. 19, 1947, unless otherwise noted.

§ 203.1 Statutory provisions.

The term ''employee'' means (1) any individual in the service of one or more employers for compensation, (2) any individual who is in the employment relation to one or more employers, and (3) an employee representative. The term ''employee'' shall include an employee of a local lodge or division defined as an employer in sub-section (a) only if he was in the service of or in the employment relation to a carrier on or after the enactment date. The term ''employee representative'' means any officer or official representative of a railway labor organization other than a labor organization included in the term ''employer'' as defined in section 1(a) who before or after the enactment date was in the service of an employer as defined in section 1(a) and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act, as amended, and any individual who is regularly assigned to or regularly employed by such officer or official representative in connection with the duties of his office.

The term ''employee'' shall not include any individual while such individual is engaged in the physical operations consisting of the mining of coal, the preparation of coal, the handling (other than movement by rail with standard railroad locomotives) of coal

not beyond the mine tipple, or the loading of coal at the tipple.

An individual is in the service of an employer whether his service is rendered within or without the United States if (i) he is subject to the continuing authority of the employer to supervise and direct the manner of rendition of his service, or he is rendering professional or technical services and is integrated into the staff of the employer, or he is rendering, on the property used in the employer's operations, other personal services the rendition of which is integrated into the employer's operations, and (ii) he renders such service for compensation, or a method of computing the monthly compensation for such service is provided in section 3(c): *Provided*, *however*, That an individual shall be deemed to be in the service of an employer, other than a local lodge or division or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States only when he is rendering service to it in the United States; and an individual shall be deemed to be in the service of such a local lodge or division only if (1) all, or substantially all, the individuals constituting its membership are employees of an employer conducting the principal part of its business in the United States; or (2) the headquarters of such local lodge or division is located in the United States; and an individual shall be deemed to be in the service of such a general committee only if (1) he is representing a local lodge or division described in clauses (1) or (2) immediately above; or (2) all, or substantially all, the individuals represented by it are employees of an employer conducting the principal part of its business in the United States; or (3) he acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer, but in such case if his office or headquarters is not located in the United States and the individuals represented by such general committee are employees of an employer not conducting the principal part of its business in the United States, only such proportion of the remuneration for such service shall be regarded as compensation as the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, unless such mileage formula is inapplicable in which case the Board may prescribe such other formula as it finds to be equitable, and if the application of such mileage formula, or such other formula as the Board may prescribe, would result in the compensation of the individual being less than 10 per centum of his remuneration for such service no part of such remuneration shall be regarded as compensation: *Provided further*, That an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required under the laws applicable in the place where the service is rendered to employ therein, in whole or in part, citizens or residents thereof; and the laws applicable on August 29, 1935, in the place where the service is rendered shall be deemed to have been applicable there at all times prior to that date.

§ 203.2 General definition of employee.

An individual shall be an employee whenever (a) he is engaged in performing compensated service for an employer or (b) he is in an employment relation to an employer, or (c) he is an employee representative, or (d) he is an officer of an employer.

§ 203.3 When an individual is performing service for an employer.

(a) The legal relationship of employer and employee is defined by the act. Thus, an individual is performing service for an employer if:

(1) He is subject to the right of an employer, directly or through another, to supervise and direct the manner in which his services are rendered; or

(2) In rendering professional or technical services he is integrated into the staff of the employer; or

(3) He is rendering personal services on the property used in the operations of the employer and the services are integrated into those operations.

(b) The provisions in paragraph (a) of this section are controlling irrespective of whether the service is performed on a part-time basis, and, with respect to paragraph (a)(1) of this section, irrespective of whether the right to supervise and direct is exercised.

§ 203.4 When service is compensated.

Service shall be ''compensated'' if it is performed for compensation, as that term is defined in part 222 of this chapter: *Provided, however,* That service prior to September 1941 of a station employee whose duties consisted of or included the carrying of passengers' hand baggage and otherwise assisting passengers at passenger stations shall be considered compensated service although the individual's remuneration was, in whole or in part, in the form of tips. (For the effect of compensation of less than $3.00 per month earned after December 31, 1936, for service to a local lodge or division of a railway-labor-organization employer, see part 222 of this chapter.)

(Sec. 3, 50 Stat. 310, as amended; 45 U.S.C. 228c)

§ 203.5 Service outside the United States.

(a) An individual shall not be an employee by reason of rendition of service to an employer other than a local lodge or division, or a general committee of a railway-labor-organization employer, not conducting the principal part of its business in the United States except while engaged in performing service for it in the United States.

(b) An individual shall not be an employee by reason of rendition of service to a local lodge or division, unless:

(1) All, or substantially all the individuals constituting the membership of such local lodge or division are employees of an employer conducting the principal part of its business in the United States; or

(2) The headquarters of such local lodge or division is located in the United States.

(c) An individual shall not be an employee by reason of rendition of service to a general committee of a railway-labor-organization employer, unless:

(1) Such individual is representing a local lodge or division, all or substantially all of whose members are employees of an employer conducting the principal part of its business in the United States, or the headquarters of such local lodge or division is located in the United States; or

(2) All or substantially all the individuals represented by such a general committee are employees of an employer conducting the principal part of its business in the United States; or

(3) Such an individual acts in the capacity of a general chairman or an assistant general chairman of a general committee which represents individuals rendering service in the United States to an employer; *Provided, however,* That if the office or headquarters of such general chairman or assistant general chairman is not located within the United States he will not be an employee unless 10 percent or more of his remuneration for service as general chairman or assistant general chairman is creditable as compensation, the creditable compensation to be computed according to the proportion which the mileage in the United States under the jurisdiction of such general committee bears to the total mileage under its jurisdiction, or according to a formula to be prescribed by the Board if the mileage formula is inapplicable.

§ 203.6 Age, citizenship, and other factors.

The age, citizenship, or residence of an individual, or his designation as other than an ''employee'' shall not be controlling in determining whether or not such individual is an employee within the meaning of the act, except that an individual not a citizen or resident of the United States shall not be deemed to be in the service of an employer when rendering service outside the United States to an employer who is required by the laws of the place where the service is performed to employ, in whole or in part, citizens or residents thereof and the laws in force therein on August 29, 1935, shall be deemed to have been in force at all times prior to that date.

[Board Order 55–89, 20 FR 3706, May 27, 1955]

§ 203.7 Local lodge employee.

An individual who, prior to January 1, 1937, shall have rendered service to a

local lodge or division of a railway labor organization included as an employer under section 1(a) of the act, shall be an employee with respect to such service to such local lodge or division only if he was on August 29, 1935, in the service of or in an employment relation to an employer which was a carrier. An individual who, subsequent to December 31, 1936, shall have rendered service to a local lodge or division of a railway labor organization included as an employer under section 1(a) of the act, shall be an employee with respect to such service to such local lodge or division only with respect to such service as was preceded by service, or an employment relation, on or after August 29, 1935, to an employer which was a carrier. (For the effect of compensation less than $3.00 per month earned after December 31, 1936, for service to a local lodge or division of a railway-labor-organization employer, see part 222 of this chapter.)

PART 204—EMPLOYMENT RELATION

Sec.

204.1 Introduction.
204.2 Employment relation—determination by the Board.
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204.7 Employment relation—service to a local lodge or division of a railway labor organization.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 54 FR 5224, Feb. 2, 1989, unless otherwise noted.

§ 204.1 Introduction.

In order for an individual to receive credit under the Railroad Retirement Act (Act) for railroad service prior to 1937, he or she must establish that he or she was actively working for an employer under the Act on August 29, 1935, or was in an employment relation to an emp]oyer on that date. Section 204.3 of this part defines employment relation for purposes of establishing prior service. It is also necessary to establish an employment relation to an employer for any month in which an individual wishes to receive a deemed service month, as provided for in § 210.3 of this chapter, and to receive credit for pay for time lost as provided for in § 211.3 of this chapter. This part defines employment relation for these purposes. See §§ 204.5 and 204.6. In addition, in order for an individual to have his or her service to a local lodge or division of a railway labor organization considered as creditable service under the Act, he or she must establish that he or she was working for a railroad or in an employment relation to a railroad on or after August 29, 1935, and that such employment or employment relation preceded his or her service to the local lodge or division. Section 204.7 defines employment relation for this purpose.

§ 204.2 Employment relation—determination by the Board.

The existence or non-existence of an employment relation, as defined in this part, is a conclusion which must be reached by the Board or its authorized officers or employees upon the basis of the evidence before the agency. The employer and the employee are the principal sources of evidence with respect to a determination whether an employment relation existed, but the Board will not be bound by the mere conclusion of the employer or the employee that the employee had or did not have an employment relation.

§ 204.3 Employment relation—prior service.

An individual shall have an employment relation to an employer on August 29, 1935, for purposes of crediting service prior to January 1, 1937, if:

(a) He or she was in the service of an employer on that date; or

(b) He or she was on that date on 1eave of absence expressly granted by the employer or by a duly authorized representative of such employer, but only if such leave of absence was established to the satisfaction of the Board before July 1947; or

(c) He or she was in the service of an employer after that date and before January 1946, in each of six calendar months, whether or not consecutive; or

(d) Before that date he or she did not retire and was not retired or discharged from the service of the last

employer by whom he or she was employed, but solely by reason of a physical or mental disability he or she ceased before August 29, 1935, to be in the service of such employer and thereafter remained continuously disabled until he or she attained age sixty-five or until August 1945; or

(e) Solely for the reason stated in paragraph (c) of this section an employer by whom he or she was employed before August 29, 1935, did not on or after August 29, 1935, and before August 1945, call him or her to return to service, or if he or she were called to return to service he or she for such reason was unable to render service in six calendar months as provided in paragraph (b) of this section; or

(f) He or she was on August 29, 1935, absent from the service of an employer by reason of a discharge which, within one year after the effective date thereof, was protested to an appropriate labor representative or to the employer, as wrongful, and which was followed within ten years of the effective date thereof by his or her reinstatement in good faith to his or her former service with all his or her seniority rights.

§ 204.4 Conditions which preclude an employment relation.

(a) An individual shall not have been on August 29, 1935, an employee by reason of an employment relation if, during the last payroll period in which he or she rendered service to an employer prior to that date, such service was rendered outside of the United States to an employer not conducting the principal part of its business in the United States.

(b) An individual may not acquire an employment relation solely by virtue of service to a local lodge or division of a railway labor organization.

§ 204.5 Employment relation—deemed service.

For the purpose of crediting deemed service months as provided in § 210.3(b) of this chapter, an individual must have maintained an employment relation to one or more employers in the month or months to be deemed. For that purpose an employment relation exists with respect to any month in which an individual, although not in the active service of an employer, is on furlough subject to recall by an employer, is on a bona fide leave of absence, has not been retired or discharged but was by reason of continuous disability unable to return to service, or was not in active service because of a discharge later determined to be wrongful. However, an employment relation with respect to an employer ceases after an individual has resigned or relinquished his or her rights to return to the service of that employer or after the individual becomes entitled to receive an annuity under the Railroad Retirement Act.

§ 204.6 Employment relation—pay for time lost.

For the purpose of crediting pay for time lost as provided in § 211.3 of this chapter, an individual must have maintained an employment relation to one or more employers in the month or months to be credited with pay for time lost. For that purpose an employment relation exists with respect to any month in which an individual, although not in the active service of an employer, is on furlough subject to recall by an employer, is on a bona fide leave of absence, has not been retired or discharged but was by reason of continuous disability unable to return to service, or was not in active service because of a discharge later determined to be wrongful. However, an employment relation with respect to an employer ceases after an individual has resigned or relinquished his or her rights to return to the service of that employer.

§ 204.7 Employment relation—service to a local lodge or division of a railway labor organization.

Service by an individual to a local lodge or division of a railway labor organization shall be creditable under the Railroad Retirement Act only if, prior to such service, and on or after August 29, 1935, such individual performed compensated service for a carrier employer under part 202 of this chapter or was in an employment relation to such a carrier employer under the rules set forth in § 204.3 of this part.

PART 205—EMPLOYEE REPRESENTATIVE

Sec.
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AUTHORITY: 45 U.S.C. 231, 45 U.S.C. 231f, 45 U.S.C. 231h.

SOURCE: 53 FR 39255, Oct. 6, 1988, unless otherwise noted.

§ 205.1 Introduction.

This part sets out the various factors considered in determining an individual's status as an employee representative under section 1(b)(1) of the Railroad Retirement Act, and discusses the procedure for reporting and crediting of compensation and service as an employee representative under that Act. An employee representative is considered to be a covered employee under the provisions of the Railroad Retirement Act.

§ 205.2 Definition of employee representative.

(a) An individual shall be an employee representative within the meaning of the Railroad Retirement Act if he or she is an officer or official representative of a railway labor organization, other than a labor organization included in the term ''employer'' within the meaning of part 202 of these regulations, who before or after August 29, 1935, was in the service of an ''employer'' within the meaning of part 202 of these regulations and who is duly authorized and designated to represent employees in accordance with the Railway Labor Act, as amended.

(b) An individual is also considered to be an employee representative within the meaning of the Act if he or she is regularly assigned to or regularly employed by an individual described in paragraph (a) of this section in connection with the duties of the office of employee representative of said individual.

(c) *Example:* A is employed by railroad R as a carman. He is also employed as recording secretary for the local chapter of union U, which has been recognized as the collective bargaining representative of the carmen of R. Although U represents some railroad employees, it is not a railway labor organization as described in part 202 of these regulations. A is an employee representative. His service for U is treated as employee service under the Railroad Retirement Act.

§ 205.3 Factors considered in determining employee representative status.

The following factors, among others, are considered by the Board in determining an individual's status as an employee representative:

(a) The name of the last railroad or other employer under the Act by which the individual was employed, and the period of employment;

(b) The present official name of the organization by which the individual is employed, as well as any other name(s) under which that organization operated previously;

(c) The date on which the organization was founded;

(d) The title of the position held by the individual within the organization, and the duties of said position;

(e) The method by which the individual, or the person to whom he or she is regularly assigned or by whom he or she is regularly employed, was authorized to represent members of the organization in negotiating with their employers, the date on which the individual was so authorized, and the time period covered by said authorization;

(f) The purpose or business of the organization as reflected by its constitution and by-laws;

(g) The extent to which the organization is, and has been recognized as, representative of crafts or classes of employees in the railroad industry;

(h) The extent to which the purposes and businesses of the organization are and have been to promote the interests of employees in the railroad industry as indicated by:

(1) The specific employee group(s) represented; and

(2) The proportion of members that are employed by railroad employers in relation to those members that are employed by non-railroad employers;

(i) Whether the organization has been certified by the National Mediation Board as a representative of any class of employees of any company;

(j) If the organization has not been certified as representative of any class of employees, the manner and method by which the organization determined that it was the duly authorized representative of such employees;

(k) Whether the organization participates or is authorized to participate in the selection of labor members of the National Railroad Adjustment Board; and

(l) Whether the organization was assisted by any carrier by railroad, express company, or sleeping car company, directly or indirectly, in its formation, in influencing employees to join the organization, financially, or in the collection of dues, fees, assessments, or any contributions payable to the organization.

§ 205.4 Claiming status as an employee representative.

An individual who claims status as an employee representative shall file a report in accordance with § 209.10 of this chapter.

(Approved by the Office of Management and Budget under control number 3220–0014)

§ 205.5 Reports of an employee representative.

An annual report of creditable compensation shall be made by an employee representative in accordance with § 209.10 of this chapter.

(Approved by the Office of Management and Budget under control number 3220–0014)

§ 205.6 Service of an employee representative.

Service rendered as an employee representative is creditable in the same manner and to the same extent as though the organization by which the employee representative was employed were an employer under the Railroad Retirement Act. (Creditable railroad service is discussed under part 210 of the Board's regulations.)

§ 205.7 Termination of employee representative status.

The employee representative status of any individual shall terminate whenever the individual or the organization by whom he or she is employed loses any of the characteristics essential to the existence of employee representative status.

PART 206—ACCOUNT BENEFITS RATIO

Sec.

206.1 Definitions.
206.2 Computations.

AUTHORITY: 45 U.S.C. 231f(b)(5); 45 U.S.C. 231u(a).

SOURCE: 68 FR 51153, Aug. 26, 2003, unless otherwise noted.

§ 206.1 Definitions.

Except as otherwise expressly noted, as used in this part—

Account benefits ratio means the amount determined by the Railroad Retirement Board by dividing the fair market value of the assets in the Railroad Retirement Account and the National Railroad Retirement Investment Trust (and for years prior to 2002, the Social Security Equivalent Benefit Account) as of the close of each fiscal year by the total benefits and administrative expenses paid from those accounts during the fiscal year.

Administrative expenses paid means the amount of the cash transfers from the Railroad Retirement Account to the agency's single administrative fund. Also included in this term is the amount of the cash transfers from the Railroad Retirement Account to the Limitation on the Office of Inspector General and the administrative expenses paid by the National Railroad Retirement Investment Trust.

Assets means the market value of cash and investments in the Railroad Retirement Account and the National Railroad Retirement Investment Trust (and for years before 2002, the Social Security Equivalent Benefit Account).

Average account benefits ratio means for any calendar year, the average of the account benefits ratio for the 10 most recent fiscal years ending before

such calendar year. If the amount computed is not a multiple of 0.1, such amount shall be increased to the next highest 0.1.

Total benefits paid means the total amount of benefits paid from the Railroad Retirement Account and the National Railroad Retirement Investment Trust in a fiscal year minus any benefit overpayments actually recovered during that fiscal year.

§ 206.2 Computation.

(a) On or before November 1, 2003, the Railroad Retirement Board shall:

(1) Compute the account benefits ratios for each of the most recent 10 preceding fiscal years; and

(2) Certify the account benefits ratio for each such fiscal year to the Secretary of the Treasury.

(b) On or before November 1 of each year after 2003, the Railroad Retirement Board shall:

(1) Compute the account benefits ratio for the fiscal year ending in such year; and

(2) Certify the account benefits ratio for such fiscal year to the Secretary of the Treasury.

(c) No later than May 1 of each year, beginning 2003, the Board shall compute its projection of the account benefits ratio and the average account benefits ratios for each of the next succeeding 5 fiscal years.

PART 209—RAILROAD EMPLOYERS' REPORTS AND RESPONSIBILITIES

Sec.

209.1 General.
209.2 Duty to furnish information and records.
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209.11 Employee representatives' reports.
209.12 Certificates of service months and compensation.
209.13 Employers' gross earnings reports.
209.14 Report of separation allowances subject to tier II taxation.
209.15 Compensation reportable when paid.
209.16 Disposal of payroll records.
209.17 Use of payroll records as returns of compensation.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46729, Nov. 28, 1984, unless otherwise noted.

§ 209.1 General.

Benefits under the Railroad Retirement Act are based in part upon an individual's years of service and amount of compensation credited to the individual under the Act. It is the duty of the Board to gather, keep and compile such records and data as may be necessary to assure proper administration of the Act. This part sets forth the types of reports employers are required to make to the Board and states the penalties that the Board may impose upon employers and employees who fail or refuse to make required reports.

§ 209.2 Duty to furnish information and records.

In the administration of the Railroad Retirement Act of 1974, the Board may require any employer or employee to furnish or submit any information, records, contracts, documents, reports or other materials within their possession or control, that, in the judgment of the Board, may have any bearing upon:

(a) The employer status of any individual, person or company,

(b) The employee or pension status of any individual,

(c) The amount and creditability of service and compensation, or

(d) Any other matter arising which involves the administration of the Railroad Retirement Act. Any person who knowingly fails or refuses to make any report or furnish any information required by the Board, may be punished by a fine of not more than $10,000 or by imprisonment not exceeding one year, or both.

(Approved by the Office of Management and Budget under control number 3220–0089)

[49 FR 46729, Nov. 2, 1984, as amended at 52 FR 11016, Apr. 6, 1987]

§ 209.3 Social security number required.

Each employer shall furnish to the Board a social security number for each employee for whom any report is submitted to the Board. Employers are encouraged to validate any social security number provided under this section.

(Approved by the Office of Management and Budget under control number 3220–0008)

[63 FR 32613, June 15, 1998]

§ 209.4 Method of filing.

Any report or information required to be furnished under this part shall be prepared in accordance with instructions of the Board and shall be filed with the Board electronically, which includes the use of magnetic tape, computer diskette, electronic data interchange, or on such form as prescribed by the Board. If not filed electronically, reports shall be transmitted by facsimile or mailed directly to the Board. Any report which includes, or should include, information for 250 or more employees must be filed electronically, as described in this section.

[63 FR 32613, June 15, 1998]

§ 209.5 Information regarding change in status.

It is the duty of each employer to promptly notify the Board of:

(a) Any change in the employer's operations, ownership or control of the employer which affects its status as an employer under the Railroad Retirement Act and the Railroad Unemployment Insurance Act;

(b) Any change in the ownership or control by the employer in any company which may affect the status of the company as an employer under the Railroad Retirement Act or Railroad Unemployment Insurance Act; and

(c) The gain of ownership or control by the employer of any company which may give that company status as an employer under the Railroad Retirement Act and Railroad Unemployment Insurance Act. The notice must fully advise the Board of the type of change in ownership, the date of the change, the number of employees affected by the change and any other information pertinent to the change.

[49 FR 46729, Nov. 28, 1984. Redesignated at 63 FR 32613, June 15, 1998]

§ 209.6 Employers' notice of death of employees.

Each employer shall notify the Board immediately of the death of an employee who, prior to the employee's death, performed compensated service which has not been reported to the Board.

(Approved by the Office of Management and Budget under control number 3220–0005)

[63 FR 32613, June 15, 1998]

§ 209.7 Employers' supplemental reports of service.

Each employer shall furnish the Board a report of the current year service of each employee who ceases work for the purpose of retiring under the provisions of the Railroad Retirement Act.

(Approved by the Office of Management and Budget under control number 3220–0005)

[63 FR 32613, June 15, 1998]

§ 209.8 Employers' annual reports of creditable service and compensation.

Each year, on or before the last day of February, each employer is required to make an annual report of the creditable service and compensation (including a report that there is no compensation or service to report) of employees who performed compensated service in the preceding calendar year. The annual report shall include service and compensation previously furnished in supplemental reports and notices of death.

(Approved by the Office of Management and Budget under control number 3220–0008)

[63 FR 32613, June 15, 1998]

§ 209.9 Employers' adjustment reports.

(a) The Board may request employers to submit adjustments to correct employee accounts when:

(1) Errors are detected in processing employers' annual report;

(2) An employee shows that the amount of service or compensation reported by the employer to the employee's account was not correct; or

(3) An employee shows that he or she should have been credited with service and compensation for a period for which the employer reported no service and compensation.

(b) Employers may submit adjustment reports to:

(1) Correct service and compensation previously reported; and

(2) Report service and compensation that was omittted from a previous report.

(c) Employers submitting adjustment reports covering pay for time lost as an employee shall report this compensation as provided for in § 211.3 of this chapter. Adjustment reports may be submitted to the Board each month.

(Approved by the Office of Management and Budget under control number 3220–0008)

[49 FR 46729, Nov. 28, 1984. Redesignated and amended at 63 FR 32613, June 15, 1998]

§ 209.10 Terminated employers' reports.

When an employer's status as an employer is terminated, a final report of creditable service and compensation shall be made. The final report shall be submitted to the Board on or before the last day of the month following the final month for which there was compensated service. The report shall be completed as prescribed in § 209.8(a) of this part and shall be marked Final Compensation Report.

(Approved by the Office of Management and Budget under control number 3220–0008)

[49 FR 46729, Nov. 28, 1984. Redesignated and amended at 63 FR 32613, June 15, 1998]

§ 209.11 Employee representatives' reports.

An individual claiming status as an employee representative shall describe his or her duties as an employee representative on the form prescribed by the Board. The Board shall determine whether the individual claiming to be an employee representative meets the requirements for such a status. If the individual is determined to be an employee representative, he or she is required to make an annual report of creditable compensation as provided for in § 209.8 of this part. If an employee representative's status is terminated, the last report of service and compensation shall be marked Final Compensation Report.

(Approved by the Office of Management and Budget under control number 3220–0014)

[63 FR 32613, June 15, 1998]

§ 209.12 Certificates of service months and compensation.

(a) Each year the Board shall provide each employee who performed compensated service in the preceding calendar year a certificate of service months and compensation. This certificate is the employee's record of the service and compensation credited to his or her account at the Board. An employee who for any reason does not receive a certificate may obtain one from the nearest Board district office or may write the Board for one.

(b) By April 1 of each year each employer shall provide the Board the current address of each employee for whom it had reported compensation. This requirement shall not apply in the case of an employee for whom the employer had previously provided an address.

(Approved by the Office of Management and Budget under control number 3220–0194)

[63 FR 32613, June 15, 1998]

§ 209.13 Employers' gross earnings reports.

(a) Each employer is required to report the gross earnings of a one-percent sample group of railroad employees. The gross earnings sample is based on the earnings of employees whose social security numbers end with the digits 30. This report is used to determine:

(1) Tax and benefit amounts involved in the Financial Interchange with the Social Security Administration and the Health Care Financing Administration; and

(2) Estimated tax income accruing to the railroad retirement system in future periods.

(b) Employers shall submit reports annually for employees in the gross earnings sample. Such reports shall include the employee's gross annual

earnings, which includes all compensation taxable under the hospital insurance portion of the tier I tax rate. Employers with 5,000 or more employees shall provide a monthly or quarterly breakdown of the year's earnings. Employers with fewer than 5,000 employees may submit an annual amount only, although a monthly or quarterly breakdown is preferable. Gross earnings are to be counted for the same time period as used in determining the employer's annual report of creditable compensation. The reports are to be prepared in accordance with prescribed instructions and filed in accordance with § 209.4 of this part.

(Approved by the Office of Management and Budget under control number 3220–0132)

[49 FR 46729, Nov. 28, 1984, as amended at 55 FR 26430, June 28, 1990; 57 FR 4365, Feb. 5, 1992; 59 FR 2292, Jan. 14, 1994. Redesignated and amended at 63 FR 32613, 32614, June 15, 1998]

§ 209.14 Report of separation allowances subject to tier II taxation.

For any employee who is paid a separation payment, the employer must file a report of the amount of the payment. This report shall be submitted to the Board on or before the last day of the month following the end of the calendar quarter in which payment is made. The report is to be prepared in accordance with prescribed instructions and filed in accordance with § 209.4 of this part.

(Approved by the Office of Management and Budget under control number 3220–0173)

[63 FR 32614, June 15, 1998]

§ 209.15 Compensation reportable when paid.

(a) *General.* In preparing a report required under this part, an employer may report compensation in the report required for the year in which the compensation was paid even though such compensation was earned by the employee in a previous year. If compensation is reported with respect to the year in which it was paid, it shall be credited by the Board to the employee in such year unless within the four year period provided in § 211.15 of this chapter the employee requests that such compensation be credited to the year in which it was earned. If the employee makes such a request, and the Board determines that the compensation should be credited to the year in which it was earned, the reporting employer must file an adjustment report as required by § 209.9 of this part which reports such compensation in the year in which it was earned. The employee may revoke his or her request anytime prior to the filing of the adjustment report. Upon the Board's receipt of the adjustment report, the request becomes irrevocable.

(b) *Pay for time lost.* Compensation which is pay for time lost, as provided in § 211.3 of this chapter, shall be reported with respect to the period in which the time and compensation were lost. For example, if an employee is off work because of an on-the-job injury for a period of months in a given year and in a later year receives a payment from his or her employer to compensate for wages lost during the period of absence, the employer must, by way of adjustment provided for in § 209.9 of this part, report the compensation with respect to the year in which the time and compensation were lost.

(c) *Separation allowance or severance pay.* A separation allowance or severance payment shall be reported in accordance with § 209.14 of this part.

(d) *Miscellaneous pay.* Miscellaneous pay, as defined in § 211.11 of this chapter, shall be reported in the year paid and reported on the annual report of compensation as provided for in § 209.8 of this part.

(e) *Vacation pay.* Vacation pay may be reported in accordance with this section except that any payments made in the year following the year in which the employee resigns or is discharged shall be reported by way of adjustment under § 209.9 of this part as paid in the year of resignation or discharge.

[58 FR 45250, Aug. 27, 1993, as amended at 63 FR 32614, June 15, 1998]

§ 209.16 Disposal of payroll records.

Employers may dispose of payroll records for periods subsequent to 1936, *provided that* the payroll records are more than five years old and that there is no dispute pending pertaining to the

compensation reported for the period of those records.

[61 FR 31395, June 20, 1996]

§ 209.17 Use of payroll records as returns of compensation.

Payroll records of employers which have permanently ceased operations may be accepted in lieu of prescribed reports *provided that* there is no official of the employer available to prepare and certify to the accuracy of such reports and, *provided further that* any employer and employee tax liability incurred under the Railroad Retirement Tax Act has been discharged.

[61 FR 31395, June 20, 1996]

PART 210—CREDITABLE RAILROAD SERVICE

Sec.
210.1 General.
210.2 Definition of service.
210.3 Month of service.
210.4 Year of service.
210.5 Creditability of service.
210.6 Service credited for creditable military service.
210.7 Verification of service claimed.

AUTHORITY: 45 U.S.C. 231f.

§ 210.1 General.

An individual's entitlement to benefits and the amount of benefits payable under the Railroad Retirement Act are determined based, in part, on the individual's years of service. This part defines what the term service means under the Railroad Retirement Act and sets forth what types of service are creditable under that Act.

[49 FR 46731, Nov. 28, 1984]

§ 210.2 Definition of service.

Service means a period of time for which an employee receives payment from a railroad employer for the performance of work; or a period of time for which an employee receives compensation which is paid for time lost as an employee; or a period of time credited to an employee for creditable military service as defined in part 212 of this chapter. Service shall also include deemed months of service as provided under § 210.3(b) of this chapter and any month in which an employee is credited with compensation under § 211.12 of this chapter based on benefits paid under title VII of the Regional Rail Reorganization Act of 1973.

[53 FR 17182, May 16, 1988]

§ 210.3 Month of service.

(a) *Reported.* A reported month of service is any calendar month or any part of a calendar month for which an employee receives compensation for services performed for an employer; or receives pay for time lost as an employee; or is credited with compensation for a period of creditable military service; or is credited with compensation under § 211.12 of this chapter based on benefits paid under title VII of the Regional Rail Reorganization Act of 1973.

(b) *Deemed.* A deemed month of service is any additional month of service credited to an employee subject to paragraphs (b)(1) and (2) of this section.

(1) An employee who is credited with less than twelve reported months of service for a calendar year after 1984 may be ''deemed'' to have performed service for compensation in additional months, not to exceed twelve, providing:

(i) The employee's compensation for the calendar year in question exceeds an amont calculated by multiplying the number of reported months credited for that year by an amount equal to one-twelfth of the current annual maximum for non-tier I components as defined in § 211.15 of this chapter; and

(ii) The employee maintains an employment relation to one or more employers or serves as an employee representative in the month or months to be deemed. For purposes of this section, employment relation has the same meaning as defined in part 204 of this chapter, disregarding the restrictions involving the establishment of such a relationship as of August 29, 1935. Employee representative has the same meaning as defined in part 205 of this chapter.

(2) Employees satisfying the conditions in both paragraphs (b)(1)(i) and (b)(1)(ii) of this section shall have their months of service for a calendar year calculated using the following formula:

$$\text{Months of service} = \frac{\text{Employee's creditable non-tier I compensation}}{\text{Maximum annual creditable non-tier I compensation} \div 12}$$

The quotient obtained using this formula equals the employee's total months of service, reported and deemed, for the calendar year. Any fraction or remainder in the quotient is credited as an additional month of service.

(3) *Examples*. The provisions of paragraphs (b)(1) and (2) of this section may be illustrated by the following examples.

Example (1): Employee B worked in the railroad industry in 1985 and was credited with nine reported months of service (January through September) and non-tier I compensation of $20,000. The 1985 annual maximum for non-tier I compensation is $29,700. B maintained an employment relation in the three months he was not employed in 1985. The following computations are necessary to determine if B has sufficient non-tier I compensation to be credited with deemed months of service.

(1) Enter the annual maximum for non-tier I compensation for the calendar year $29,700
(2) Divide line (1) by 12
$29,700÷12 ..... $2,475
(3) Enter the employee's reported months of service for the calendar year 9
(4) Multiply line (2) by line (3) $2,475×9 ..... $22,275
(5) Enter the employee's non-tier I compensation for the calendar year $20,000
(6) Subtract line (4) from line (5). Enter the result (but not less than zero). This is the employee's excess non-tier I compensation for the calendar year.
$20,000 − $22,275 0

a. If line (6) is zero, the employee does not have sufficient non-tier I compensation to be credited with deemed months of service.

b. If line (6) is greater than zero, the employee has sufficient non-tier I compensation to be credited with deemed months of service.

Since the amount on line (6) is zero, employee B does not have enough non-tier I compensation to be credited with deemed months of service. B is credited with only nine reported months of service for the year.

Example (2): Assume the same facts as in example (1), except that employee B was credited with non-tier I compensation of $25,000 for 1985. The following computations are necessary to determine if B has sufficient non-tier I compensation to be credited with deemed months of service.

(1) Enter the annual maximum for non-tier I compensation for the calendar year $29,700
(2) Divide line (1) by 12
$29,700÷12 ..... $2,475
(3) Enter the employee's reported months of service for the calendar year 9
(4) Multiply line (2) by line (3) $2,475×9 ..... $22,275
(5) Enter the employee's non-tier I compensation for the calendar year $25,000
(6) Subtract line (4) from line (5). Enter the result (but not less than zero). This is the employee's excess non-tier I compensation for the calendar year.
$25,000 − $22,275 ..... $2,725

a. If line (6) is zero, the employee does not have sufficient non-tier I compensation to be credited with deemed months of service.

b. If line (6) is greater than zero, the employee has sufficient non-tier I compensation to be credited with deemed months of service.

Since the amount on line (6) is greater than zero, employee B has enought non-tier I compensation to be credited with deemed months of service. B now satisfies all the requirements for deeming, therefore his months of service for the calendar year are calculated using the formula in § 210.3(b)(2).

$$\text{Months of service} = \frac{\text{Employee's creditable non-tier I compensation}}{\text{Maximum annual creditable non-tier I compensation} \div 12}$$

$$\text{(1)} \quad \text{Months of service} = \frac{\$25{,}000}{\$29{,}700 \div 12} \text{ or } \$25{,}000 \div \$2{,}475$$

$$(2)\quad \text{Months of service} = \frac{\$25{,}000}{\$2{,}475} \text{ or } \$25{,}000 \div \$2{,}475$$

(3) Months of service = 25,000÷2,475 or 10.10

(4) Round the result in line (3) to the next higher whole number. This is the employee's total months of service for the calendar year.

10.10 becomes 11

Employee B is credited with 11 months of service for 1985; nine reported months (January through September) and two deemed months (October and November).

[53 FR 17182, May 16, 1988]

§ 210.4 Year of service.

(a) A year of service is twelve months of reported or deemed service, consecutive or not consecutive. A fraction of a year of service is taken at its actual value.

(b) The term years of service means the total number of years an employee is credited with service as defined in § 210.2 of this part.

[49 FR 46731, Nov. 28, 1984, as amended at 53 FR 17183, May 16, 1988]

§ 210.5 Creditability of service.

(a) *Service before January 1, 1937.* (1) Service performed before January 1, 1937, is called prior service. Prior service is creditable under the Railroad Retirement Act if the employee had an employment relation with a railroad employer on August 29, 1935. Prior service may be combined with creditable service performed after December 31, 1936, to make the employee's total years of service equal, but not exceed, 30 years (360 months).

(2) An employee is considered to have an employment relation on August 29, 1935, if:

(i) The employee was on that date in active railroad service for an employer; or

(ii) The employee was on that date on a leave of absence expressly granted by the employer or the employer's authorized representative, but only if such leave of absence was established to the satisfaction of the Board before July 1947; or

(iii) The employee had 6 months of active railroad service for an employer during the period August 29, 1935, through December 31, 1945; or

(iv) The employee was not in the service of an employer by reason of a mental or physical disability from which the employee was continuously disabled until the employee attained age 65 or until August 1945; or

(v) Solely for the reason stated in paragraph (a)(2)(iv) of this section the employee was not recalled to active service before August 1945; or

(vi) If the employee was recalled, the employee was unable to perform 6 months of service during the period August 29, 1935, through December 31, 1945, solely for the reason stated in paragraph (a)(2)(iv) of this section.

(b) *Service after December 31, 1936.* All service performed after December 31, 1936, is creditable. If an employee has service both before January 1, 1937, and after December 31, 1936, all service after December 31, 1936, is credited first; if this service totals less than 30 years (360 months), then the service before January 1, 1937, is included but only up to the amount sufficient to make the total years of service equal 30. Where the years of service include only part of the service performed before January 1, 1937, the part included is taken in reverse order beginning with the last calendar month of the service.

(c) *Service after December 31, 1936, to a local lodge or division.* Services performed for a local lodge or division of a railway labor organization is creditable if the employee is credited with compensation as defined in § 211.2 of this chapter.

(d) *Service based on time lost.* Any month or any part of a month during which an employee performed no active service but received pay for time lost as an employee is counted as a month of service. Service for time lost as an employee shall be credited as provided for in § 211.3 of this chapter.

(e) *Place of performance of service.* (1) Service performed for an employer who

conducts the principal part of its business with the United States is creditable. However, service performed for an employer who conducts the principal part of its business outside the United States is creditable only when the service is performed in the United States. If an employer, other than a local lodge or division or a general committee of a railway labor organization, does not conduct the principal part of its business within the United States, the service performed outside the United States for that employer is not creditable.

(2) Service performed outside the United States by an employee who is not a citizen or resident of the United States is not creditable if the employer is required under the laws of that place to hire, in whole or in part, only citizens or residents of that place.

(f) *Service as employee representative.* Service performed as an employee representative is creditable in the same manner and to the same extent as service performed for an employer.

(g) *Service performed after the beginning date of an annuity.* Service performed after the beginning date of an annuity shall be used in the annuity recomputation.

[49 FR 46731, Nov. 28, 1984, as amended at 53 FR 17184, May 16, 1988]

§ 210.6 Service credited for creditable military service.

Any calendar month in which an employee performed creditable military service, as defined in part 212 of this chapter, shall be counted as a month of service and shall be included in the employee's years of service, as provided for in § 210.5, provided that the employee has not previously been credited with reported or deemed service for an employer for the same month(s).

[53 FR 17184, May 16, 1988]

§ 210.7 Verification of service claimed.

Service claimed by an employee, which is not credited in the records of the Board, must be verified to the satisfaction of the Board before it may be credited. Verification of the Service claimed shall be as follows:

(a) Service claimed will be verified from the payroll or other detailed records of the employer.

(b) If the payroll or other detailed records are incomplete or missing, the service claimed and not established by these records will be verified from the personnel records of the employer.

(c) If the payroll, personnel and detailed records are incomplete or missing, the service claimed and not established by these records will be verified from any other books and records of the employer.

(d) If the employer's records do not establish the service claimed, the employee may submit affidavits and other evidence in support of the service claimed in either of the following instances:

(1) When there are no employer records available to show whether or not the service claimed was performed; or

(2) When there are employer records available which do not verify the service claimed and do not establish that the service claimed was not performed.

(e) When service is verified as to over-all dates, but is not supported in detail by employer records, and when there are no employer records showing in detail absences from service, a deduction shall be made to cover an average amount of the absences. The deduction shall be the absences shown by the applicant or 5 percent of the total period in question, whichever is greater. However, where the employee submits detailed records of the service claimed, properly identified and established as having been made at the time the employee performed the service for which detailed records of the employer are not available, full credit may be allowed for the service as may be verified from the records. Also, the employee may be permitted to establish in any other manner satisfactory to the Board the actual amount of his or her absences.

(f) For the purpose of verifying service before 1937, employers shall preserve through 1986, in accessible form, the original records of the service and compensation.

(g) For the purpose of verifying service after 1936, employers shall preserve in accessible form the original records

of service and compensation for a period of five calendar years after the due date of the report.

(Approved by the Office of Management and Budget under control numbers 3220–0003 and 3220–0008)

[49 FR 46731, Nov. 28, 1984, as amended at 52 FR 11016, Apr. 6, 1987]

PART 211—CREDITABLE RAILROAD COMPENSATION

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46732, Nov. 28, 1984, unless otherwise noted.

§ 211.1 General.

Benefits under the Railroad Retirement Act are based in part on the individual's years of service and amount of compensation credited to the individual under the Act. This part defines what the term compensation means and sets forth the criteria applied in determining what payments are creditable as compensation under the Railroad Retirement Act.

§ 211.2 Definition of compensation.

(a) The term compensation means any form of payment made to an individual for services rendered as an employee for an employer; services performed as an employee representative; and any separation or subsistence allowance paid under any benefit schedule provided in conformance with title VII of the Regional Rail Reorganization Act of 1973 and any termination allowance paid under section 702 of that Act. Compensation may be paid as money, a commodity, a service or a privilege. However, if an employee is to be paid in any form other than money, the employer and employee must agree before the service is performed upon the following:

(1) The value of the commodity, service or privilege; and

(2) That the amount agreed upon to be paid may be paid in the form of the commodity, service or privilege.

(b) Compensation includes, but is not limited to, the following:

(1) Salary, wages and bonuses;

(2) Pay for time lost as an employee;

(3) Cash tips of $20 or more received in a calendar month;

(4) Vacation pay;

(5) Military pay as determined in § 211.7 of this part;

(6) Displacement allowances as provided for in § 211.8 of this part;

(7) Dismissal allowances as provided for in § 211.9 of this part;

(8) Separation allowances as provided for in § 211.10 of this part;

(9) Miscellaneous pay as provided for in § 211.11 of this part;

(10) Payments made under title VII of the Regional Rail Reorganization Act of 1973 as provided for in § 211.12 of this part.

(11) Payments paid to an employee or employee representative which are subject to tax under section 3201(a) or 3211(a) of the Internal Revenue Code of 1954 are creditable as compensation under the Railroad Retirement Act for purposes of computation of benefits under sections 3(a)(1), 3(f)(3), 4(a)(1) and 4(f)(1).

(12) Voluntary payments of any tax by an employer, without deducting such tax from the employee's salary.

(13) Payments made by an employer with respect to a deceased employee except as provided for in § 211.13 of this part.

(c) Compensation does not include:

(1) Tips, except as provided in paragraph (b)(3) of this section;

(2) Payments for services performed by a nonresident alien for the period the individual is temporarily present in the United States as a nonimmigrant

under subparagraph (F) or (J) of section 1101(a)(15) of title 8, U.S.C. and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be;

(3) Remuneration paid in certain cases, as described below, for services performed for a local lodge or division of a railway labor organization.

(i) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after 1936 and prior to April 1, 1940, shall not be creditable as compensation in a month unless taxes with respect to such remuneration were paid under the Railroad Retirement Tax Act prior to July 1, 1940.

(ii) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after March 31, 1940, and prior to January 1, 1975, shall not be creditable as compensation in a month if the amount of such remuneration earned in the month is less than $3.00.

(iii) Remuneration for services rendered for a local lodge or division of a railway labor organization which was earned after December 31, 1974, shall not be creditable as compensation in a month if the amount of such remuneration earned in the month is less than $25.00.

(4) Payments for service as a delegate to a national or international convention of a railway-labor-organization employer if the individual rendering the service has not previously rendered service, other than as a delegate, which may be included in the individual's years of service;

(5) Except as provided in § 211.2(b)(11), the amount of any payment (including any amount paid by an employer for insurance or annuities, or into a fund, to provide for any such payment) made to, or on behalf of, an employee or any of the employee's dependents under a plan or system established by an employer which makes provisions for employees generally (or for employees generally and their dependents), or for a class or classes of employees (or for a class or classes of employees and their dependents), on account of sickness or accident disability, or medical, or hospitalization expenses in connection with sickness or accident disability; and

(6) Any amount paid specifically—either as an advance, as reimbursement or allowance—for traveling or other bona fide and necessary expenses incurred, or reasonably expected to be incurred in the business of the employer, provided the payment is identified by the employer either by a separate payment or by specifically indicating the separate amounts where both wages and expense reimbursement or allowance are combined in a single payment.

[49 FR 46732, Nov. 28, 1984, as amended at 53 FR 17184, May 16, 1988; 58 FR 45251, Aug. 27, 1993]

§ 211.3 Compensation paid for time lost.

(a) A payment made to an employee for a period during which the employee was absent from the active service of the employer is considered to be pay for time lost and is, therefore, creditable compensation. Pay for time lost as an employee includes:

(1) Pay received for a certain period of time due to personal injury, or

(2) Pay received for loss of earnings for a certain period of time, resulting from the employee being placed in a position or occupation paying less money. In reporting compensation which represents pay for time lost, employers shall allocate the amount paid to the employee to the month(s) in which the time was actually lost. The entire amount of any payment made to an employee for personal injury is considered pay for time lost unless, at the time of payment, the employer states that a particular amount of the payment was for reasons other than pay for time lost.

(b) Where pay for time lost is allocated to the month(s) in which the time was actually lost, the Board will accept the allocation made by the parties involved if it relates to the employee's normal monthly pay. A reasonable relationship to an employee's normal monthly pay is ordinarily no less than ten times the employee's daily pay rate.

§ 211.4 Vacation pay.

Payments made to an employee with respect to vacation or holidays shall be

considered creditable compensation whether or not the employee takes the vacation or holiday.

[58 FR 45251, Aug. 27, 1993]

§ 211.5 Employee representative compensation.

All payments made by a railway labor organization to an individual who is an employee representative as a result of the position or office he occupies with such organization are creditable as compensation, including payments made for services not connected with the representation of employees, except that payments in excess of the annual maximum amount will not be credited.

[53 FR 17184, May 16, 1988]

§ 211.6 Compensation based on waiver or refund of organization dues.

A waiver or refund or organization dues which was based solely on consideration for membership in the organization is considered creditable compensation if there is proof that the waiver or refund was intended to be, and was accepted as, a dismissal of an obligation of the organization to compensate the employee for services rendered.

[53 FR 17184, May 16, 1988]

§ 211.7 Compensation credited for creditable military service.

In determining the creditable compensation of an employee, the following amounts shall be credited for each month of military service, provided the employee's combined monthly railroad and military compensation does not exceed the maximum creditable amount:

(a) $160 for each calendar month before 1968;

(b) $260 for each calendar month after 1967 and before 1975;

(c) For years after 1974, the actual military earnings reported as wages under the Social Security Act.

[53 FR 17184, May 16, 1988]

§ 211.8 Displacement allowance.

An allowance paid to an employee because he has been displaced to a lower paying position is creditable compensation.

[58 FR 45251, Aug. 27, 1993]

§ 211.9 Dismissal allowance.

Dismissal allowances paid to an employee under a protective labor agreement that covers the amounts paid for specific periods of time are creditable as compensation under the Railroad Retirement Act, provided the employee has not severed his or her employee-employer relationship.

[53 FR 17184, May 16, 1988, as amended at 58 FR 45251, Aug. 27, 1993]

§ 211.10 Separation allowance or severance pay.

Separation or severance payments are creditable compensation except that no part of such payment shall be considered creditable compensation to any period after the employee has severed his or her employer-employee relationship except as provided for in § 211.11 of this part.

[58 FR 45251, Aug. 27, 1993]

§ 211.11 Miscellaneous pay.

Any payment made to an employee by an employer which is excluded from compensation under the Railroad Retirement Act, but which is subject to taxes under the Railroad Retirement Tax Act, shall be considered compensation for purposes of this part but only for the limited purpose of computing the portion of the annuity computed under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act (commonly called the tier I component).

[58 FR 45251, Aug. 27, 1993]

§ 211.12 Compensation credited for title VII benefits.

Payments made to an employee under title VII of the Regional Rail Reorganization Act of 1973 are creditable as compensation only for the month in which the employee first filed an application for benefits under that Act. The compensation to be credited cannot exceed the monthly creditable amounts defined in § 211.13(a) of this part for compensation earned prior to 1985 or the annual creditable amount defined

in § 211.13(b) of this part for compensation earned after 1984.

[53 FR 17185, May 16, 1988]

§ 211.13 Payments made after death.

Payments made by an employer with respect to a deceased employee but paid after the calendar year of the employee's death to the employee's survivors or estate are not creditable compensation.

[58 FR 45251, Aug. 27, 1993]

§ 211.14 Maximum creditable compensation.

Maximum creditable compensation for calendar years after 1984 is the maximum annual taxable wage base defined in section 3231(e)(2)(B) of the Internal Revenue Code of 1986. In November of each calendar year the Director of Research and Employment Accounts shall notify each employer of the amount of maximum creditable compensation applicable to the following calendar year.

[58 FR 45251, Aug. 27, 1993]

§ 211.15 Verification of compensation claimed.

Compensation claimed by an employee, which is not credited in the records of the Board, must be verified to the satisfaction of the Board before it may be credited. An employee's claim to compensation not credited shall be processed as follows:

(a) If the compensation claimed is in excess of the maximum creditable amounts defined in § 211.13 of this part, the Director of the Bureau of Research and Employment Accounts shall inform the employee that the compensation claimed is not creditable.

(b) If the compensation is claimed within four years from the date the compensation was required to be reported to the Board as prescribed in § 209.6 of this chapter, the Director of Research and Employment Accounts shall contact the employer requesting a review of their records, and if the employee's claim is correct, the employer will submit an adjustment crediting the employee with the compensation claimed. If the employer states that the employee's claim is incorrect, the employee will be requested to submit check stubs to show railroad retirement taxes withheld from the compensation claimed. Upon receipt of the check stubs, the proof will be sent to the employer along with a request for the employer to submit an adjustment crediting the employee with the compensation claimed.

[49 FR 46732, Nov. 28, 1984, as amended at 53 FR 17185, May 16, 1988. Redesignated at 58 FR 45251, Aug. 27, 1993]

§ 211.16 Finality of records of compensation.

(a) *Time limit for corrections to records of compensation.* The Board's record of the compensation reported as paid to an employee for a given period shall be conclusive as to amount, or if no compensation was reported for such period, then as to the employee's having received no compensation for such period, unless the error in the amount of compensation or the failure to make return of the compensation is called to the attention of the Board within four years after the date on which the compensation was required to be reported to the Board as provided for in § 209.6 of this chapter.

(b) *Correction after 4 years.* (1) The Board may correct a report of compensation after the time limit set forth in paragraph (a) of this section where the compensation was posted or not posted as the result of fraud on the part of the employer.

(2) Subject to paragraph (c) of this section, the Board may correct a report of compensation after the time limit set forth in paragraph (a) of this section for one of the following reasons:

(i) Where the compensation was posted for the wrong person or the wrong period;

(ii) Where the earnings were erroneously reported to the Social Security Administration in the good faith belief by the employer or employee that such earnings were not covered under the Railroad Retirement Act and there is a final decision of the Board under part 259 of this chapter that such employer or employee was covered under the Railroad Retirement Act during the period in which the earnings were paid;

(iii) Where a determination pertaining to the coverage under the Railroad Retirement Act of an individual,

partnership, or company as an employer, is retroactive; or

(iv) Where a record of compensation could not otherwise be corrected under this part and where in the judgment of the three-member Board that heads the Railroad Retirement Board failure to make a correction would be inequitable.

(c) *Limitation on crediting service.* (1) Except as provided in paragraph (b)(1) of this section, no employee may be credited with service months or tier II compensation beyond the four year period referred to in paragraph (a) of this section unless the employee establishes to the satisfaction of the Board that all employment taxes imposed by sections 3201, 3211, and 3221 of title 26 of the Internal Revenue Code have been paid with respect to the compensation and service.

(2) The limitation on the creditability of service months and tier II compensation in paragraph (c)(1) of this section shall not affect the creditability, for purposes of computing the tier I component of a railroad retirement annuity, of compensation payments with respect to which taxes have been paid under either the Railroad Retirement Tax Act or the Federal Insurance Contributions Act.

[62 FR 3790, Jan. 27, 1997]

PART 212—MILITARY SERVICE

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 49 FR 46734, Nov. 28, 1984, unless otherwise noted.

§ 212.1 General.

In determining an individual's entitlement and amount of benefits under the Railroad Retirement Act, an individual's military service creditable under the Railroad Retirement Act is used. This part defines military service as used under this Act and sets forth the criteria to determine the creditability of military service.

§ 212.2 Military service defined.

Military service is the performance of active service by an individual in the armed forces of the United States. An individual is considered to be in active military service when commissioned or enrolled in the land, naval or air forces of the United States until resignation or discharge therefrom. The service of an individual in any reserve component of the land, naval or air forces of the United States, during any period in which ordered to active duty, even though less than thirty days, is also considered active service. However, service in the Army Specialist Corps and the Merchant Marine is not creditable under the Railroad Retirement Act.

§ 212.3 Crediting of military service.

In determining an individual's entitlement to an annuity and the amount of annuity to be paid under the Railroad Retirement Act, a calendar month or part of a calendar month during which the individual was in the active military service of the United States in a war service period, or period of national emergency, as determined in §212.4 of this part, may be included in the individual's years of service. Military service is credited as though the individual had performed service for a railroad employer as provided for in part 210 of this chapter, provided that the individual is credited with railroad service in the year of or the year before entrance into active military service. Compensation for creditable military service shall be credited as provided for in §211.7 of this chapter.

§ 212.4 Periods of creditable military service.

In order for military service to be considered to be creditable under the Railroad Retirement Act, it must have been performed during one of the following periods:

(a) April 21, 1898, through August 13, 1898—Spanish American War;

(b) February 4, 1899, through April 27, 1902—Philippine Insurrection;

(c) May 9, 1916, through February 5, 1917—Mexican Border Disturbances;

(d) April 6, 1917, through November 11, 1918—World War I;

(e) September 8, 1939, through June 14, 1948—National Emergency and World War II. Individuals required to continue in service after this period may be credited with the service if:

(1) They were in military service on December 31, 1946, or

(2) They were required to remain in military service involuntarily after December 31, 1946;

(f) June 15, 1948, through December 15, 1950. This service is creditable if:

(1) Entered into involuntarily; or

(2) Entered into voluntarily, but only if:

(i) The individual who seeks credit for this service performs service as an employee for an employer as defined in part 202 of this chapter either in the year of his or her release from active military service or in the year following such release, and;

(ii) The individual does not engage in any employment not covered by part 203 between his or her release from active military service and his or her commencement of service for an employer.

(g) December 16, 1950, through September 14, 1978—National Emergency.

[49 FR 46734, Nov. 28, 1984, as amended at 55 FR 20454, May 17, 1990]

§ 212.5 Verification of military service.

Military service may be verified by the following proof:

(a) The original certificate of discharge or release to inactive duty from a branch of the armed forces that shows the beginning and ending dates of the individual's active military service; or a certified copy of the original certificate made by the Federal, State, county or municipal agency or department in which the original certificate is recorded; or

(b) A certificate from a branch of the armed forces that shows the beginning and ending dates of the individual's active military service; or

(c) A photocopy of the document described in paragraph (a) or (b) of this section.

§ 212.6 Board's determination for use of military service.

(a) Military service may be creditable under both the Railroad Retirement and Social Security Acts, but there are provisions under those Acts to prevent duplicate use of the service. The Railroad Retirement Board will determine whether an employee's military service should be used as railroad service or as Social Security service. The Board's determination is intended to be to the employee's advantage; however, if the employee does not agree with the Board's determination for use of the employee's military service, the employee may request that it be changed.

(b) Generally, it is to the employee's advantage for the employee's military service to be creditable as railroad service where any of the following conditions may be met with the use of the employee's military service as railroad service:

(1) It gives the employee 10 years of service (120 months), which is the minimum needed to qualify for an annuity based on age and service or total disability, as provided for in part 216, subpart B; or

(2) It gives the employee 20 years of service (240 months), which is the minimum needed to qualify for an occupational disability annuity, as provided for in § 216.6 of this chapter; or

(3) It gives the employee 25 years of service (300 months), which is the minimum needed to qualify for a supplemental annuity, as provided for in part 216, subpart C; or

(4) It gives the employee 30 years of service (360 months), which would allow the employee to retire at age 60 with a full annuity and will also provide a full annuity to a qualified spouse at age 60, as provided for in part 216, subparts B and D; or

(5) It gives the employee sufficient railroad service to entitle the employee to vested dual benefit payments, as provided for in part 216, subpart H.

(c) In certain cases it may be to the employee's advantage for the employee's military service to be credited under the Social Security Act. This is generally true under the following conditions:

(1) Crediting the military service under the Social Security Act would entitle the employee and any eligible children to social security benefits, since direct benefits are not payable to

children of retired employees under the Railroad Retirement Act; or

(2) Crediting the military service under the Social Security Act would entitle employee to vested dual benefit payments.

PART 216—ELIGIBILITY FOR AN ANNUITY

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AUTHORITY: 45 U.S.C. 231f.

SOURCE: 56 FR 28692, June 24, 1991, unless otherwise noted.

Subpart A—General

§ 216.1 Introduction.

This part explains when an individual is eligible for a monthly annuity under the Railroad Retirement Act. An individual eligible for an annuity as described in this part may become entitled to an annuity only in such amount as set forth in parts 225 through 229 of this chapter

(a) *Regular annuity*. A regular monthly annuity is provided for:

(1) An employee who retires because of age or disability;

(2) An employee's spouse or divorced spouse; or

(3) The widow, widower, child, parent, remarried widow or widower, or surviving divorced spouse of an employee.

(b) *Supplemental annuity*. An employee who retires because of age or disability may also be entitled to a supplemental annuity.

§ 216.2 Definitions.

Except as otherwise expressly noted, as used in this part—

Age means an individual's age on the day preceding the anniversary date of his or her birth.

Annuity means a payment due an entitled individual for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Railroad Retirement Board accepts as an application for benefits under the rules set out in part 217 of this chapter.

Attainment of age means that an individual attains a given age on the first moment of the day preceding the anniversary date of his or her birth corresponding to such numerical age.

Board means the Railroad Retirement Board.

Claimant means an individual who files an annuity application or for whom an annuity application is filed.

Eligible means that an individual meets all the requirements for payment of an annuity but has not yet applied for one.

Employee means an individual who is or has been in the service of an employer as here defined.

Employer means a company, individual, or other entity determined to be a covered employer under the Railroad Retirement Act as provided by part 202 of this chapter.

Entitled means that an individual has applied for and has established his or her rights to benefits.

Railroad Retirement Act means the Railroad Retirement Act of 1974, as amended.

Re-entitled annuity means an annuity to which an individual becomes entitled after an earlier-awarded annuity has been terminated. A re-entitled annuity is usually awarded on the basis of different factors of eligibility from the initial annuity, and may be awarded without the filing of another application.

Retirement age means, with respect to an employee who attains age 62 before January 1, 2000 (age 60 in the case of a widow(er), remarried widow(er) or surviving divorced spouse) age 65. For an employee who attains age 62 (or age 60 in the case of a widow(er), remarried widow(er), or surviving divorced spouse) after December 31, 1999, retirement age means the age provided for in section 216(1) of the Social Security Act.

Social Security Act means the Social Security Act as amended.

Tier I benefit means the benefit component calculated using Social Security Act formulas and based upon earnings covered under both the Railroad Retirement Act and the Social Security Act.

Tier II benefit means the benefit component calculated under a formula found in the Railroad Retirement Act and based only upon earnings and service in the railroad industry.

Year of service means 12 calendar months, consecutive or otherwise, of service creditable to an employee as described in part 210 of this chapter.

§ 216.3 Other regulations related to this part.

This part is related to a number of other parts. Part 217 of this chapter describes how to apply for an annuity. Part 218 indicates when annuities begin and when they terminate. Part 219 sets out what evidence is necessary to prove

eligibility. Where eligibility for an annuity is based upon a family relationship to an employee (for example, a widow's annuity), the definition of such family relationship may be found in part 222 of this chapter. Part 225 of this chapter describes the computation of the primary insurance amount.

Subpart B—Current Connection With the Railroad Industry

§ 216.11 General.

A current connection with the railroad industry is required to qualify for certain types of railroad retirement benefits. The existence of a current connection is clear in most cases where entitlement or death immediately follows continuous years of railroad employment. However, there are cases in which the employee did not work for a railroad employer for a period of time before entitlement or death. In these situations, special tests are applied to determine whether the employee can be considered to have a current connection with the railroad industry for the purpose of determining his or her eligibility for an annuity or other benefits.

§ 216.12 When current connection is required.

(a) A current connection is required to qualify an individual for the following types of railroad retirement benefits:

(1) An employee occupational disability annuity as described in subpart D of this part;

(2) A supplemental annuity as described in subpart E of this part;

(3) An employee vested dual benefit in certain cases;

(4) A survivor annuity as described in subparts G, H, and I of this part; and

(5) A lump-sum death payment as described in part 234 of this chapter.

(b) A current connection which was established when an employee's annuity began is effective for:

(1) Any annuity under this part for which the employee later becomes eligible; and

(2) Any survivor annuity under this part or a lump-sum death payment under part 234 of this chapter.

§ 216.13 Regular current connection test.

An employee has a current connection with the railroad industry if he or she meets one of the following requirements:

(a) The employee has creditable railroad service in at least 12 of the 30 consecutive months immediately preceding the earlier of:

(1) The month his or her annuity begins; or

(2) The month he or she dies.

(b) The employee has creditable railroad service in at least 12 months in a period of 30 consecutive months and does not work in any regular non-railroad employment in the interval between the month the 30-month period ends and the earlier of:

(1) The month his or her annuity begins; or

(2) The month he or she dies.

§ 216.14 Regular non-railroad employment that will not break a current connection.

Regular non-railroad employment will not break an employee's current connection if it is performed during the 30-month period described in § 216.13(b), in or after the month the annuity begins, or in the month the employee dies.

§ 216.15 Special current connection test.

(a) *For survivor annuities.* An employee who does not have a current connection under the regular test has a current connection only to qualify an individual for a survivor annuity if:

(1) The employee would not be fully or currently insured under section 214 of the Social Security Act if his or her railroad compensation after 1936 were treated as social security earnings;

(2) The employee has no quarters of coverage as defined in section 213 of the Social Security Act; or

(3) The employee received a pension or a retirement annuity that began before 1948 based on at least 114 months of service.

(b) *For survivor and supplemental annuities.* An employee who does not have a current connection under the regular test has a current connection in order

to pay a supplemental or survivor annuity if he or she meets all of the following requirements:

(1) Has been credited with at least 25 years of railroad service;

(2) Stopped working in the railroad industry ''involuntarily and without fault'' on or after October 1, 1975, or was on furlough, leave of absence or absent for injury on that date;

(3) Did not decline an offer of employment in the same ''class or craft'' as his or her most recent railroad service; and

(4) Was alive on October 1, 1981.

(c) *''Involuntarily and without fault'' defined.* An employee is considered to have stopped railroad employment involuntarily and without fault if:

(1) The employee loses his or her job;

(2) The employee could not, through the exercise of seniority rights, remain in railroad service in the same class or craft as his or her most recent railroad service, regardless of the location where that service would be performed; and

(3) The employee did not lose his or her job because of poor job performance, misconduct, medical reasons or other action or inaction on the part of the employee.

(d) *Effect of separation allowance.* An employee who accepts a separation allowance and in so doing relinquishes his or her seniority rights to railroad employment is deemed to have voluntarily terminated his or her railroad service. However, if the employee stopped railroad employment involuntarily and without fault, as defined in paragraph (c) of this section, receipt of a separation allowance will not affect a current connection under paragraph (b) of this section.

(e) *''Class or craft'' defined.* The terms''class or craft,'' as used in this section, have the same meaning as they do generally in the railroad industry.

(f) *For supplemental annuities only.* An additional special current connection test is required for an individual who was receiving a disability annuity which terminated due to the individual's recovery from disability. If the individual becomes entitled to a new annuity, a new current connection test based on the new annuity beginning date must be made. This test is made using the rules contained in §§ 216.13 and 216.17.

§ 216.16 What is regular non-railroad employment.

(a) Regular non-railroad employment is full or part-time employment for pay.

(b) Regular non-railroad employment does not include any of the following:

(1) Self-employment;

(2) Temporary work provided as relief by an agency of a Federal, State, or local government;

(3) Service inside or outside the United States for an employer under the Railroad Retirement Act, even if the employer does not conduct the main part of its business in the United States;

(4) Involuntary military service not creditable under the Railroad Retirement Act;

(5) Employment with the following agencies of the United States Government:

(i) Department of Transportation;

(ii) Interstate Commerce Commission;

(iii) National Mediation Board;

(iv) Railroad Retirement Board;

(v) National Transportation Safety Board; or

(vi) Surface Transportation Board.

(6) Employment entered into after early retirement by an employee who is receiving an annuity under Conrail's voluntary annuity program. This program is provided under the Staggers Rail Act of 1980 (Pub. L. 96–448); or

(7) Employment with the Alaska Railroad so long as it is an instrumentality of the State of Alaska.

[56 FR 28692, June 24, 1991, as amended at 62 FR 11324, Mar. 12, 1997]

§ 216.17 What amount of regular non-railroad employment will break a current connection.

The amount of regular non-railroad employment needed to break a current connection depends on when the applicable 30-month period ends (see § 216.13 of this part), as follows:

(a) If the 30-month period ends in the calendar year before or in the same calendar year as the annuity begins or the

month the employee dies, the current connection is broken if the employee:

(1) Works in each month in the interval after the end of the 30-month period and before the earlier of the month the annuity begins or the employee dies; or

(2) Works and earns at least $200 in wages in any 3 months within the interval described in paragraph (a)(1) of this section.

(b) If the 30-month period ends more than a year before the calendar year in which the annuity begins or the employee dies, the current connection is broken if the employee:

(1) Works in any 2 consecutive years wholly or partially within the interval after the end of the 30-month period and before the month the annuity begins or the employee dies, whichever is earlier; and

(2) Earns at least $1,000 in wages in any year wholly or partially within the interval described in paragraph (b)(1) of this section (but not counting earnings during the 30-month period and after the annuity beginning date), even if that year is not one of the 2 consecutive years described in paragraph (b)(1) of this section.

Subpart C—Railroad and Last Non-Railroad Employment

§ 216.21 General.

To be eligible for an employee, a spouse, or a divorced spouse annuity, the Railroad Retirement Act requires that an applicant must stop work for pay performed as an employee for a railroad employer. In addition, no employee, spouse or divorced spouse annuity may be paid for any month in which the employee, spouse or divorced spouse annuitant works for pay for any railroad employer after the date his or her annuity began. No annuity may be paid to a widow or widower, surviving divorced spouse, remarried widow or widower, child, or parent for any month such individual works for pay for a railroad employer.

§ 216.22 Work as an employee which affects payment.

(a) *Work for a railroad employer.* Work for pay as an employee of a railroad employer always prevents payment of an annuity.

(b) *Work for last non-railroad employer.* Work for pay in the service of the last non-railroad employer by whom an individual is employed will reduce the amount of the tier II benefit of the employee, spouse and supplemental annuity as provided in part 230 of this chapter. An individual's last non-railroad employer is:

(1) Any non-railroad employer from whom the individual last resigned (in point of time) in order to receive an annuity; and

(2) Any additional non-railroad employer from whom the individual resigned in order to have an annuity become payable. Employment which an individual stops within 6 months of the date on which the individual files for an annuity will be presumed in the absence of evidence to the contrary to be service from which the individual resigned in order to receive an annuity.

(c) *Corporate officers.* An officer of a corporation will be considered to be an employee of the corporation. A director of a corporation acting solely in his or her capacity as such director is not an employee of the corporation.

§ 216.23 Work which does not affect eligibility.

An individual may engage in any of the following without adversely affecting his or her annuity:

(a) *Work for a railway labor organization.* An individual may work for a local lodge or division of a railway labor organization if the pay is under $25 a month, unless the work performed is solely for the purpose of collecting insurance premiums.

(b) *Work without pay.* Work performed for any person or entity for which no pay is received, or where the pay merely constitutes reimbursement for out-of-pocket expenses, or where the amount received consists only of free will donations and there is no agreement that such donation shall constitute remuneration for services, does not affect entitlement to an annuity.

(c) *Self-employment.* Self-employment is work performed in an individual's own business, trade or profession as an independent contractor, rather than as an employee. An individual is not self-employed if the business is incorporated. The designation or description

of the relationship between the individual and another person as anything other than that of an employer and employee is immaterial. If the Board determines that an employer-employee relationship exists, the fact that the employee is designated as a partner, coadventurer, agent, independent contractor, or the like will be disregarded. An individual determined to be an employee of a railroad employer pursuant to part 203 of this chapter is not self-employed. Whether an individual performing services is an employee depends upon the degree to which the recipient of services controls the individual's work. Control is determined in accordance with general legal principles delineating an employer-employee relationship. Among the factors considered are:

(1) *Instructions.* An individual required to comply with instructions about when, where, and how to work is ordinarily an employee. Instructions may be oral or in the form of manuals or written procedures which show how the desired result is to be accomplished. An individual who ordinarily works without receiving instructions because he or she is highly skilled or knowledgeable may nevertheless be an employee if the employer has a right to instruct the individual in performance of the work.

(2) *Training.* Training provided an individual by an employer indicates that the employer wants the work to be performed in a particular method or manner, especially if the training is given periodically or at frequent intervals. An individual may be trained by an experienced employee working with him or her, by correspondence, by required attendance at meetings, or by other methods.

(3) *Integration into the employer's business.* Integration of an individual's services into the business operations of an employer generally shows that the individual is subject to direction and control. When the success or continuation of a business depends to an appreciable degree upon the performance of certain services, the individuals who perform those services must necessarily be subject to a certain amount of control by the owner of the business.

(4) *Services rendered personally.* A requirement that an individual personally work for the employer indicates that the employer is interested in the methods as well as the results, and that the employer intends to control the result by controlling who does the work.

(5) *Hiring, supervising, and payment of assistants.* An employer generally hires, supervises, and pays assistants. An individual who hires, supervises, and pays other workers at the direction of the employer may be an employee acting as a representative of the employer. However, if an individual hires, supervises, and pays his or her own assistants pursuant to a contract under which the individual agrees to provide materials and labor and under which the individual is responsible only for the attainment of a result, this factor indicates an independent contractor status.

(6) *Continuing work relationship.* A work relationship between an individual and an employer which continues over time indicates that the individual is an employee. A relationship may continue if the individual works at frequently recurring, though somewhat irregular intervals, either on call of the employer or when work is available.

(7) *Set hours of work.* A requirement that an individual work for an employer during a specified period of the day, week, month or year, or for a specified number of hours daily indicates that the individual is an employee. An individual whose occupation renders fixed hours impractical may be an employee if required by the employer to work at certain times.

(8) *Full time required.* A requirement that an individual devote full time to the employer's business indicates that the individual is an employee. What full time means may vary with the intent of the parties, the nature of the occupation, and customs in the locality. Full-time work may be required indirectly even though not specified in writing or orally. An individual required to produce a minimum volume of business for an employer may be compelled to devote full time to producing the work. Prohibiting work for

any other employer may require an individual to work full time to earn a living However, part-time work performed on a regular basis, or on call of the employer, or when work is available, may also render an individual an employee.

(9) *Working on employer's premises.* Working on the employer's premises may indicate that an individual is an employee where by nature the work could be done elsewhere, because the employer's place of business is physically within the employer's direction and supervision. Desk space, telephone, and stenographic services provided by an employer place the worker within the employer's direction and supervision unless the worker has the option not to use these facilities. Work done off the employer's premises does not by itself indicate that the worker is not an employee because some occupations require that work be performed away from the premises of the employer. Control over the place of work is indicated when the person or persons for whom the services are performed have the right to compel the worker to travel a designated route, to canvass a territory within a certain time, or to work at specific places as required.

(10) *Order or sequence set.* Performing tasks in the order or sequence set by the employer indicates that the worker is an employee. Often, because of the nature of an occupation, the person or persons for whom the services are performed do not set the order of the services or set the order infrequently. It is sufficient to show control, however, if such person or persons retain the right to do so.

(11) *Oral or written reports.* Regular oral or written reports submitted to the employer indicate that the worker is an employee, compelled to account to the employer for his or her actions.

(12) *Payment by hour, week, month.* Payment at a fixed rate per hour, week, or month indicates that an individual is an employee. Payment by commission with a guaranteed minimum salary, or by a drawing account at stated intervals with no requirement to repay amounts which exceed the individual's earnings, also indicates that an individual is an employee. Payment in a lump sum for a completed job indicates that an individual is self-employed. The lump sum may be computed by the number of hours required to do the job at a fixed hourly rate, or by weekly or monthly installments toward a lump sum agreed upon in advance as the total cost. Payment made on a straight commission basis generally indicates that the worker is an independent contractor.

(13) *Payment of business and/or traveling expenses.* Payment by the employer of expenses which an individual incurs in connection with the employer's business indicates that the individual is an employee.

(14) *Furnishing of tools and materials.* The fact that the person or persons for whom the services are performed furnish significant tools, materials, and other equipment tends to show the existence of an employer-employee relationship.

(15) *Investment in facilities.* If the worker invests in facilities which are used by the worker in performing services and which are not typically maintained by employees, such as an office rented by the worker from a party unrelated to the worker or to the employer, this factor tends to indicate that the worker is an independent contractor. On the other hand, if all facilities necessary to the work which an individual performs are furnished without charge by the employer, this factor indicates the existence of an employer-employee relationship. Facilities include equipment or premises necessary for the work, other than items such as tools, instruments, and clothing which may be commonly provided by an employee in a particular trade.

(16) *Realization of profit or loss.* An individual not in a position to realize a profit or suffer a loss as a result of work performed for an employer is an employee. An individual has an opportunity for profit or loss if he or she:

(i) Hires, directs, and pays assistants;

(ii) Has his or her own office, equipment, materials, or other facilities for doing the work;

(iii) Has continuing and recurring liabilities or obligations, and success or failure depends on the relation of receipts to expenditures; or

(iv) Agrees to perform specific jobs for prices agreed upon in advance and

pays expenses incurred in connection with the work.

(17) *Working for more than one firm at a time.* If a worker performs more than *de minimus* services for a number of unrelated persons or firms at the same time, this factor generally indicates that the worker is an independent contractor. However, a worker who performs services for more than one person may be an employee of each of the persons, especially where such persons are part of the same service arrangement.

(18) *Making service available to the general public.* The fact that an individual makes his or her services available to the general public on a regular and consistent basis rather than to one employer indicates that the individual is self-employed rather than an employee of any one firm. An individual may make services available to the public by working from his or her own office with assistants, from his or her own home, by holding business licenses, by a listing in a business directory, or by advertising.

(19) *Employer's right to discharge.* The right to discharge a worker is a factor which indicates that the worker is an employee and the person who possesses the right is an employer. An employer exercises control through the threat of dismissal, which causes the worker to obey the employer's instructions. An employer's right to discharge exists even if it is restricted due to a collective bargaining agreement. An employer ordinarily cannot end a relationship without incurring liability with a self-employed individual who meets contract specifications.

(20) *Employee's right to terminate.* The fact that an individual has the right to end his or her relationship with an employer at any time without incurring liability for work to be performed indicates that the individual is an employee. A self-employed individual is legally obligated to satisfactorily complete a specific job.

§ 216.24 Relinquishment of rights to return to work.

(a) *What return to work rights must be given up.* Before an individual may receive an annuity based on age, he or she must give up any seniority or other rights to return to work for any railroad employer.

(b) *When right to return to work is ended.* An individual's right to return to work for a railroad employer is ended whenever any of the following events occur:

(1) The employer reports to the Board that the individual no longer has the right;

(2) The individual or an authorized agent of that individual gives the employer an oral or written notice of the individual's wish to give up that right and:

(i) The individual certifies to the Board that the right has been given up;

(ii) The Board notifies the employer of the individual's certification; and

(iii) The employer either confirms the individual's right has been given up or fails to reply within 10 days following the day the Board mailed the notice to the employer;

(3) An event occurs which under the established rules or practices of the employer automatically ends that right;

(4) The employer or the individual or both take an action which clearly and positively ends that right;

(5) The individual never had that right and permanently stops working;

(6) The Board gives up that right for the individual, having been authorized to do so by the individual;

(7) The individual dies; or

(8) The individual signs a statement that he or she gives up all rights to return to work in order to receive a separation allowance or severance pay.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220–0016)

Subpart D—Employee Annuity

§ 216.30 General.

The Railroad Retirement Act provides annuities for employees who have reached a specified age and have been credited with a specified number of years of service. The Act also provides annuities for employees who become disabled. In addition, to be eligible for an annuity an employee must comply with the work restrictions outlined in subpart C of this part.

§ 216.31 Who is eligible for an age annuity.

The Railroad Retirement Act provides annuities based on the employee's age for employees who have been credited with at least 10 years of railroad service.

(a) *Annuities based on 10 years of service.* An employee with 10 years of railroad service but less than 30 years of service is eligible for an annuity if he or she:

(1) Has attained retirement age; or

(2) Has attained age 62 (the annuity cannot begin prior to the first full month during which the employee is age 62) but is less than retirement age. All components of the annuity are reduced for each month the employee is under retirement age when the annuity begins.

(b) *Annuities based on 30 years of service.* An employee who has been credited with 30 years of railroad service is eligible for an annuity at age 60 (the annuity cannot begin prior to the first full month the employee is age 60). The Tier I component of the annuity is reduced if the employee meets the following conditions:

(1) The employee annuity begins before the month in which the employee is age 62; and either

(2) He or she had not attained age 60, prior to July 1, 1984; or

(3) He or she had not completed 30 years of railroad service prior to July 1, 1984.

(c) *Change from employee disability to age annuity.* A disability annuity paid to an employee through the end of the month before the month in which the employee attains retirement age is converted to an age annuity beginning with the month in which he or she attains retirement age.

§ 216.32 Who is eligible for a disability annuity.

The Railroad Retirement Act provides two types of disability annuities for employees who have been credited with at least 10 years of railroad service. An employee may receive an annuity if his or her disability prevents work in his or her regular railroad occupation. An employee who cannot be considered for a disability based on ability to work in his or her regular railroad occupation may receive an annuity if his or her disability prevents work in any regular employment.

(a) *Disability for work in regular railroad occupation.* An employee disabled for work in his or her regular occupation, as defined in part 220 of this chapter, is eligible for a disability annuity if he or she:

(1) Has not attained retirement age; and

(2) Has a current connection with the railroad industry; and has either:

(3) Completed 20 years of service; or

(4) Completed 10 years of service and is at least 60 years old.

(b) *Disabled for work in any regular employment.* An employee disabled for work in any regular employment, as defined in part 220 of this chapter, is eligible for a disability annuity if he or she:

(1) Is under retirement age; and

(2) Has completed 10 years of service.

§ 216.33 What is required for payment of an age or disability annuity.

In addition to the eligibility requirements listed above, an employee may be required to meet other conditions before payment of his or her annuity may begin.

(a) To receive payment of an employee annuity based on age, an eligible employee must:

(1) Apply to be entitled to an annuity; and

(2) Give up the right to return to service with his or her last railroad employer.

(b) If a disability annuity is converted to an age annuity when the annuitant attains retirement age, the age annuity cannot be paid until the employee gives up the right to return to work as described in subpart C of this part. The employee may authorize the Board to relinquish any such right on his or her behalf at the time when he or she applies for the disability annuity.

(c) To receive payment of an employee annuity based on disability, and eligible employee must apply to be entitled to an annuity.

(d) When requested, the employee must submit evidence to support his or

her application, such as proof of age or evidence of disability.

(The information collection requirements contained in this section were approved by the Office of Management and Budget under control number 3220–0002)

Subpart E—Supplemental Annuity

§ 216.40 General.

An employee with a current connection with the railroad industry at the time of retirement may qualify for a supplemental annuity in addition to the regular employee annuity. Supplemental annuities are paid from a separate account funded by employer taxes in addition to those assessed for regular annuities. The Board reduces a supplemental annuity if the employee receives a private pension based on contributions from a railroad employer.

§ 216.41 Who is entitled to a supplemental annuity.

An employee is entitled to a supplemental annuity if he or she:

(a) Has been credited with railroad service in at least one month before October 1981;

(b) Is entitled to the payment of an employee annuity awarded after June 30, 1966;

(c) Has a current connection with the railroad industry when the employee annuity begins;

(d) Has given up the right to return to work as shown in subpart C of this part; and either

(e) Is age 65 or older and has completed 25 years of service; or

(f) Is age 60 or older and under age 65, has completed 30 years of service, and is awarded an annuity on or after July 1, 1974.

§ 216.42 How a private railroad pension affects a supplemental annuity.

(a) *What is a private railroad pension.* The Board determines whether a pension established by a railroad employer is a private pension that will cause a reduction in the employee's supplemental annuity. A private pension for purposes of this subpart is a plan that:

(1) Is a written plan or arrangement which is communicated to the employees to whom it applies;

(2) Is established and maintained by an employer for a defined group of employees; and

(3) Provides for the payment of definitely determinable benefits to employees over a period of years, usually for life, after retirement or disability. Such a plan is sometimes referred to as a defined benefit plan.

(b) *Defined contribution plan.* A plan under which the employer is obligated to make fixed contributions to the plan regardless of profits (sometimes known as a money purchase plan) is a private pension plan. A plan under which the employer's contributions are discretionary is not a private pension plan under this section.

(c) *Other than retirement benefits.* A plan which provides benefits not customarily considered retirement benefits (such as unemployment benefits, sickness or hospitalization benefits) is not a private pension plan under this section.

(d) *Effective date of private railroad pension for supplemental annuity purposes.* A private pension reduces a supplemental annuity payment effective on the first day of the month after the month the Board determines that it is a private pension as defined in paragraph (a) of this section.

(e) *Effect of private railroad pension.* A supplemental annuity is reduced by the amount of any private pension the employee is receiving which is attributable to an employer's contributions, less any amount by which the private pension is reduced because of the supplemental annuity. The supplemental annuity is not reduced for the amount of a private pension attributable to the employee's contributions. The Board will determine the amount of a private pension for any month which is attributable to the employee's contributions.

§ 216.43 Effect of a supplemental annuity on other benefits.

(a) *Employee annuity.* A supplemental annuity that begins after December 31, 1974, does not affect the payment of a regular employee annuity. A supplemental annuity beginning prior to 1975 causes a reduction in the employee annuity as provided by section 3(j) of the Railroad Retirement Act of 1937.

(b) *Spouse or survivor annuity.* The payment of a supplemental annuity does not affect the amount of a spouse or survivor annuity.

(c) *Residual lump-sum.* The amount of a supplemental annuity is not deducted from the gross residual lump-sum benefit. See part 234 of this chapter for an explanation of the residual lump-sum benefit.

Subpart F—Spouse and Divorced Spouse Annuities

§ 216.50 General.

The Railroad Retirement Act provides annuities for the spouse, and divorced spouse, of an employee who is entitled to an employee annuity. A spouse may receive an annuity based on age, or on having a child of the employee in his or her care. A divorced spouse may only receive an annuity based on age. No spouse or divorced spouse annuity may be paid based upon disability.

§ 216.51 Who is eligible for a spouse annuity.

(a) To be eligible for an annuity, a spouse must:

(1) Be the husband or wife, as defined in part 222 of this chapter, of an employee who is entitled to an annuity described under subpart D of this part; and

(2) Stop working for any railroad employer.

(b) Where the employee's annuity began before January 1, 1975, the employee has completed less than 30 years of railroad service, and is age 65 or older, the spouse must be:

(1) Age 65 or older;

(2) Less than age 65 and have in his or her care a disabled child or minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 62 or older but under age 65. In such case, all annuity components are reduced for each month the spouse is under age 65 at the time the annuity begins.

(c) Where the employee's annuity begins after December 31, 1974, the employee has completed 10 years but less than 30 years of railroad service, and has attained age 62, the spouse must be:

(1) Retirement age or older;

(2) Less than retirement age and have in his or her care a disabled child or a minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 62 or older but under retirement age. In such case, all annuity components are reduced for each month the spouse is under retirement age at the time the annuity begins.

(d) Where the employee's annuity began after June 30, 1974, the employee has completed 30 years of railroad service, and is age 60 or older, the spouse must be:

(1) Age 60 or older;

(2) Less than age 60 and have in his or her care a disabled child or a minor child (a child under 18 years old if the spouse claimant is a wife, or under 16 years old if the spouse claimant is a husband) of the employee; or

(3) Age 60 but less than retirement age. In such case, the tier I component is reduced if the following conditions are met:

(i) The employee was under age 62 at the time his or her annuity began;

(ii) The employee annuity began after June 30, 1984;

(iii) The employee was under age 60 on June 30, 1984 or completed 30 years of railroad service after June 30, 1984; and

(iv) The spouse annuity begins after June 30, 1984.

§ 216.52 Who is eligible for an annuity as a divorced spouse.

To be eligible for a divorced spouse annuity, the employee annuitant must be at least age 62 and the divorced spouse (see § 222.22 of this chapter) must:

(a) Be the divorced wife or husband of an employee;

(b) Stop work for a railroad employer;

(c) Not be entitled to an old-age or disability benefit under the Social Security Act based on a primary insurance amount that is equal to or greater than one-half of the employee's tier I primary insurance amount; and either

(d) Have attained retirement age; or

(e) Have attained age 62 but be under retirement age. The annuity is reduced for each month the spouse is under retirement age at the time the annuity begins.

§ 216.53 What is required for payment.

An eligible spouse or divorced spouse must:

(a) Apply to be entitled to an annuity; and

(b) Give up the right to return to work for a railroad employer.

(Approved by the Office of Management and Budget under control number 3220–0016 and 3220–0042)

§ 216.54 Who is an employee's wife or husband.

An employee's wife or husband is an individual who—

(a) Is married to the employee; and

(b) Has been married to the employee for at least one year immediately before the date the spouse applied for annuity;

(c) Is the natural parent of the employee's child;

(d) Was entitled to an annuity as a widow(er), a parent, or a disabled child under this part in the month before he or she married the employee; or

(e) Could have been entitled to a benefit listed in paragraph (d) of this section, if the spouse had applied and been old enough in the month before he or she married the employee.

Subpart G—Widow(er), Surviving Divorced Spouse, and Remarried Widow(er) Annuities

§ 216.60 General.

The Railroad Retirement Act provides annuities for the widow(er), surviving divorced spouse, or remarried widow(er) of an employee. The deceased employee must have completed 10 years of railroad service and have had a current connection with the railroad industry at the time of his or her death. A widow(er), surviving divorced spouse, or remarried widow(er) may receive an annuity based on age, on disability, or on having a child of the employee in his or her care.

§ 216.61 Who is eligible for an annuity as a widow(er).

(a) A widow(er) of an employee who has completed 10 years of railroad service and had a current connection with the railroad industry at death is eligible for an annuity if he or she:

(1) Has not remarried; and either

(2) Has attained retirement age;

(3) Is at least 50 but less than 60 years of age and became disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity);

(4) Is less than retirement age but has in his or her care a child who either is under age 18 (16 with respect to the tier I component) or is disabled and who is entitled to an annuity under subpart H of this part; or

(5) Is at least 60 years of age but has not attained retirement age. (In this case, all components of the annuity are reduced for each month the widow(er) is age 62 or over but under retirement age when the annuity begins. For each month the widow(er) is at least age 60 but under age 62, all components of the annuity are reduced as if the widow(er) were age 62).

§ 216.62 Who is eligible for an annuity as a surviving divorced spouse.

(a) A surviving divorced spouse of an employee who completed 10 years of railroad service and had a current connection with the railroad industry at death, is eligible for an annuity if he or she:

(1) Is unmarried;

(2) Is not entitled to an old-age benefit under the Social Security Act that is equal to or higher than the surviving divorced spouse's annuity before any reduction for age; and either

(3) Has attained retirement age;

(4) Is at least 50 years of age but less than retirement age and is disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity.);

(5) Is less than retirement age but has in his or her care a child who either is under age 16 or is disabled and who is entitled to an annuity under subpart H of this part; or

(6) Is at least 60 years of age but has not attained retirement age. In this

case, the annuity is reduced for each month the surviving spouse is under retirement age when the annuity begins.

(b) A disabled surviving spouse's annuity is converted to an annuity based on age beginning the month he or she becomes 60 years old. The annuity rate does not change.

(c) If a surviving divorced spouse marries after attaining age 60 (or age 50 if he or she is a disabled surviving divorced spouse), such marriage shall be deemed not to have occurred.

§ 216.63 Who is eligible for an annuity as a remarried widow(er).

(a) A widow(er) of an employee who completed 10 years of railroad service and had a current connection with the railroad industry at death is eligible for an annuity as a remarried widow(er) if he or she:

(1) Remarried either:

(i) After having attained age 60 (after age 50 if disabled); or

(ii) Before age 60 but the marriage terminated;

(2) Is not entitled to an old-age benefit under the Social Security Act that is equal to or higher than the full amount of the remarried widow(er)'s annuity before any reduction for age; and

(3) Has attained retirement age;

(4) Is at least 50 but less than 60 years of age and is disabled as defined in part 220 of this chapter before the end of the period described in § 216.68 (this results in a reduced annuity);

(5) Has not attained retirement age but has in his or her care a child who either is under age 16 or is disabled, and who is entitled to an annuity under subpart H of this part; or

(6) Is at least age 60 but has not attained retirement age. (In this case, the annuity is reduced for each month the remarried widow(er) is under retirement age when the annuity begins.)

(b) An individual entitled to a widow(er)'s annuity may be entitled to an annuity as a remarried widow(er) if he or she:

(1) Remarries after having attained age 60 (after age 50 if he or she has been determined to be disabled prior to his or her remarriage) and is not a surviving divorced spouse; or

(2) Is entitled to an annuity based upon having a child of the employee in his or her care and marries an individual entitled to a retirement, disability, widow(er)'s, mother's, father's, parent's, or disabled child's benefit under the Railroad Retirement Act or Social Security Act.

§ 216.64 What is required for payment.

An eligible widow(er), surviving divorced spouse, or remarried widow(er) must:

(a) Apply to be entitled for an annuity; and

(b) Submit evidence requested by the Board to support his or her application.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 216.65 Who is an employee's widow(er).

An individual who was married to the employee at the employee's death is the deceased employee's widow(er) if he or she:

(a) Was married to the employee for at least 9 months before the day the employee died;

(b) Is the natural parent of the employee's child;

(c) Was married to the employee when either the employee or the widow(er) adopted the other's child, or they both legally adopted a child who was then under 18 years old;

(d) Was married to the employee less than 9 months before the employee died but, at the time of marriage, the employee was reasonably expected to live for 9 months; and

(1) The employee's death was accidental;

(2) The employee died in the line of duty while he or she was serving active duty as a member of armed forces of the United States; or

(3) The surviving spouse was previously married to the employee for at least 9 months;

(e) Was entitled in the month before the month of marriage to either:

(1) A benefit under section 202 of the Social Security Act as a widow, widower, spouse (divorced spouse, surviving divorced spouse), father, mother, parent, or disabled child; or

(2) An annuity under the Railroad Retirement Act as a widow, widower,

divorced spouse, or surviving divorced spouse, parent or disabled child; or

(f) Could have been entitled to a benefit listed in paragraph (e) of this section, if the widow(er) had applied and been old enough to qualify therefor in the month before the month of marriage.

§ 216.66 Who is an employee's surviving divorced spouse.

An individual who was married to the employee is the deceased employee's surviving divorced spouse if he or she:

(a) Was married to the employee for a period of at least 10 years immediately before the date the divorce became final, and applies for an annuity based on age or disability; or

(b) Applies for an annuity based on having a ''child in care'' and either:

(1) Is the natural parent of the employee's child;

(2) Was married to the employee at the time the employee or the surviving divorced spouse adopted the other's child who was then under 18 years old; or

(3) Was married to the employee at the time they adopted a child who was then under 18 years old.

§ 216.67 "Child in care."

(a) *Railroad Retirement Act.* Part 222 of this chapter sets forth what is required to establish that a child is in an individual's care for purposes of the Railroad Retirement Act. This definition is used to establish eligibility for the tier II component of a female spouse or widow(er) annuity under that Act. Under this definition a child must be under age 18 or under a disability before any benefit is payable based upon having the child in care.

(b) *Social Security Act.* In order to establish eligibility for the tier I components of a spouse or widow(er) annuity, and eligibility for a surviving divorced spouse annuity based upon having a child of the employee in care, the definition of ''child in care'' found in the Social Security Act is used. Under this definition, a child must be under age 16 or under a disability.

§ 216.68 Disability period for widow(er), surviving divorced spouse, or remarried widow(er).

A widow(er), surviving divorced spouse, or remarried widow(er) who has a disability as defined in part 220 of this chapter is eligible for an annuity only if the disability began before the end of a period which:

(a) Begins in the later of:

(1) The month in which the employee died;

(2) The last month for which the widow(er) or surviving divorced spouse was entitled to an annuity for having the employee's child in care; or

(3) The last month for which the widow(er) or surviving divorced spouse was entitled to a previous annuity based on disability; and

(b) Ends with the earlier of:

(1) The month before the month in which the widow(er) or surviving divorced spouse or remarried widow(er) become 60 years old; or

(2) The last day of the last month of a 7-year period (84 consecutive months) following the month in which the period began.

Subpart H—Child's Annuity

§ 216.70 General.

The Railroad Retirement Act provides an annuity for the child of a deceased employee but not for the child of a living employee. The Act does provide that the child of a living employee can establish another individual's eligibility for a spouse annuity or cause an increase in the annuities of an employee and spouse. The eligibility requirements described in this subpart also apply for the following purposes, except as otherwise indicated in this part:

(a) To establish annuity eligibility for a spouse under subpart F of this part if he or she has the employee's eligible child in care;

(b) To establish annuity eligibility for a widow(er), or surviving divorce spouse or remarried widow(er) under subpart G of this part if he or she has the employee's child in care; or

(c) To provide an increase in the employee's annuity under the Social Security Overall Minimum Guaranty (see

part 229) by including the eligible child.

§ 216.71 Who is eligible for a child's annuity.

An individual is eligible for a child's annuity if the individual:

(a) Is a child of an employee who has completed 10 years of railroad service and had a current connection with the railroad industry when he or she died;

(b) Is not married at the time the application is filed;

(c) Is dependent upon the employee as defined in part 222 of this chapter; and

(d) Meets one of the following at the time the application is filed:

(1) Is under age 18; or

(2) Is age 18 or older and either:

(i) Is disabled as defined in part 220 of this chapter before attaining age 22 (the disability must continue through the time of application for benefits);

(ii) Is under age 19 and is a full-time student as defined in § 216.74 of this part; or

(iii) Becomes age 19 in a month in which he or she is a full-time student and has not completed the requirement for, or received a diploma or certificate from, a secondary school.

§ 216.72 What is required for payment of a child's annuity.

An eligible child of a deceased employee is entitled to an annuity upon applying therefor and submitting any evidence requested by the Board.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 216.73 Who may be re-entitled to a child's annuity.

If an individual's entitlement to a child's annuity has ended, the individual may be re-entitled if he or she has not married and he or she applies to be re-entitled. The re-entitlement may begin with:

(a) The first month in which the individual is a full-time student if he or she is under age 19, or is age 19 and has not completed requirements for, or received a diploma or certificate from, a secondary school;

(b) The first month the individual is disabled, if the disability began before he or she attained age 22 and continues through the time of application for benefits; or

(c) The first month in which the individual is under a disability that began before the last day of a 7-year period (84 consecutive months) following the month in which the previous child's annuity ended, or the individual was no longer included as a disabled child in a railroad retirement annuity paid under the Social Security Overall Minimum Annuity (see part 229).

§ 216.74 When a child is a full-time elementary or secondary school student.

(a) A child is a full-time elementary or secondary school student if he or she meets all of the following conditions:

(1) The child is in full-time attendance at an elementary or secondary school; or

(2) The child is instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which the child resides; or

(3) The child is in an independent study elementary or a secondary education program administered by the local school, district, or jurisdiction, which is in accordance with the law of the State or other jurisdiction in which he or she resides.

(b) The child is in full-time attendance in a day or evening non-correspondence course of at least 13 weeks duration and he or she is carrying a subject load that is considered full-time for day students under the institution's standards and practices. If he or she is in a home schooling program as described in paragraph (a)(2) of this section, he or she must be carrying a subject load that is considered full-time for day students under the standards and practices set by the State or other jurisdiction in which the student resides.

(c) To be considered in full-time attendance, scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If the student is in an independent study program as described in paragraph (a)(3) of this section, the number of hours spent in school attendance is determined by combining

the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. The student may still be considered in full-time attendance if the scheduled rate of attendance is below 20 hours per week if the Board finds that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is the student's only reasonable alternative; or

(2) The student's medical condition prevents him or her from having scheduled attendance of at least 20 hours per week. To prove that the student's medical condition prevents him or her from scheduling 20 hours per week, the Board may request that the student provide appropriate medical evidence or a statement from the school; or

(3) The student is not attending classes, but is graduating in that month and classes ended the month before.

(d) An individual is not a full-time student if, while attending an elementary or secondary school, he or she is paid compensation by an employer who has requested or required that the individual attend the school. An individual is not a full time student while he or she is confined in a penal institution or correctional facility because he or she committed a felony after October 19, 1980.

(e) A student who reaches age 19 but has not completed the requirements for a secondary school diploma or certificate and who is a full-time elementary or secondary student, as defined in paragraph (a) of this section, will continue to be eligible for benefits until the first day of the first month following the end of the quarter or semester in which he or she is then enrolled, or if the school is not operated on a quarter or semester system, the earlier of:

(1) The first day of the month following completion of the course(s) in which he or she was enrolled when age 19 was reached; or

(2) The first day of the third month following the month in which he or she reached age 19.

[63 FR 17326, Apr. 9, 1998]

§ 216.75 When a child is a full-time student during a period of non-attendance.

A student who has been in full-time attendance at an elementary or secondary school is considered a full-time student during a period of non-attendance (include part-time attendance) if:

(a) The period of non-attendance is 4 consecutive months or less;

(b) The student shows to the satisfaction of the Board that he or she intends to return, or the student does return, to full-time attendance at the end of the period; and

(c) The student has not been expelled or suspended from the school.

Subpart I—Parent's Annuity

§ 216.80 General.

The Railroad Retirement Act provides an annuity for the surviving parent of a deceased employee. The deceased employee must have completed 10 years of railroad service and have had a current connection with the railroad industry at the time of his or her death. A parent may only receive an annuity based on age.

§ 216.81 Who is eligible for a parent's annuity.

(a) Where the employee is not survived by a widow(er), or child who is or ever could be entitled to an annuity as described by subpart G or H of this part, a parent of the deceased employee is eligible for both the tier I and tier II components of an annuity if he or she:

(1) Is age 60 or older;

(2) Has not married since the employee died;

(3) Received one-half of his or her support (as defined in part 222 of this chapter) from the employee at the time the employee died; and

(4) Files proof of support as provided for in paragraphs (b)(4) and (b)(5) of this section.

(b) Where the employee is survived by a widow(er), or child who is or ever could be entitled to an annuity as described by subpart G or H of this part, a parent of the deceased employee is eligible for an annuity consisting of the tier I component alone if he or she:

(1) Is age 60 or older;

(2) Has not married since the employee died;

(3) Is not in receipt of an old age benefit under the Social Security Act equal to or exceeding the amount of the parent's tier I annuity amount before it is reduced for the family maximum but after the sole survivor minimum is considered;

(4) Received at least one-half of his or her support (as defined in part 222 of this chapter) from the employee either:

(i) When the employee died, or

(ii) At the beginning of the period of disability if the employee has a period of disability (as explained in part 220 of this chapter) which did not end before death; and

(5) Files proof of support with the Board within 2 years after either:

(i) The month in which the employee filed an application for a period of disability if support is to be established as of the beginning of the period of disability; or

(ii) The date of the employee's death if support is to be established at that point.

(c) The Board may accept proof of support filed after the 2-year period for reasons which constitute good cause to do so as that term is defined in part 219 of this chapter.

§ 216.82 What is required for payment.

An eligible parent must file an application and submit the evidence requested by the Board to be entitled to an annuity.

(Approved by the Office of Management and Budget under control number 3220–0030)

Subpart J—Eligibility for More Than One Annuity

§ 216.90 General.

An individual may meet the eligibility provisions for more than one annuity described in this part. The Railroad Retirement Act generally requires that the total amount of annuities otherwise independently payable to one individual must be reduced if that individual is entitled to multiple annuities. Entitlement as a survivor includes entitlement as a widow(er), surviving divorced spouse, remarried widow(er), child, or parent.

§ 216.91 Entitlement as an employee and spouse, divorced spouse, or survivor.

(a) *General.* If an individual is entitled to an annuity as a spouse, divorced spouse or survivor, and is also entitled to an employee annuity, then the spouse, divorced spouse or survivor annuity must be reduced by the amount of the employee annuity. However, this reduction does not apply (except as provided in paragraph (b) of this section) if the spouse, divorced spouse or survivor or the individual upon whose earnings record the spouse, divorced spouse or survivor annuity is based worked for a railroad employer or as an employee representative before January 1, 1975.

(b) *Tier I reduction.* If an individual is entitled to an annuity as a spouse, divorced spouse or survivor, and is also entitled to an employee annuity, then the tier I component of the spouse, divorced spouse or survivor annuity must be reduced by the amount of the tier I component of the employee annuity. Where the spouse or survivor is entitled to a tier II component, then a portion of this reduction may be restored in the computation of this component.

§ 216.92 Entitlement as a spouse or divorced spouse and as a survivor.

If an individual is entitled to both a spouse or divorced spouse and survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

§ 216.93 Entitlement to more than one survivor annuity.

If an individual is entitled to more than one survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

§ 216.94 Entitlement to more than one divorced spouse annuity.

If an individual is entitled to more than one annuity as a divorced spouse, only the larger annuity will be paid. However, if the individual so chooses, he or she can receive the smaller annuity rather than the larger annuity.

PART 217—APPLICATION FOR ANNUITY OR LUMP SUM

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AUTHORITY: 45 U.S.C. 231d and 45 U.S.C. 231f.

SOURCE: 47 FR 7647, Feb. 22, 1982, unless otherwise noted.

Subpart A—General

§ 217.1 Introduction.

This part prescribes how to apply for an annuity or lump-sum payment under this chapter. It contains the rules for the filing and cancellation of an application and the period of time the application is in effect. Eligibility requirements for an annuity and for a lump-sum payment are found respectively in parts 216 and 234 of this chapter.

[54 FR 13363, Apr. 3, 1989]

§ 217.2 Definitions.

The following definitions are used in this part:

Applicant means a person who signs an application for an annuity or lump sum for himself or herself or for some other person.

Application refers only to a form described in § 217.6.

Apply or *file* means to sign a form or statement that the Railroad Retirement Board accepts as an application.

Award means to process a form to make a payment. An annuity is awarded on the date the payment form is processed.

Claimant means a person who files for an annuity or lump sum for himself or herself or the person for whom an application is filed.

§ 217.3 Need to file an application.

In addition to meeting other requirements, a person must file an application to become entitled to an annuity or lump sum. Filing an application will—

(a) Permit a formal decision on whether the person is entitled to an annuity or lump sum;

(b) Protect a person's entitlement to an annuity for as many as 12 months before the application is filed; and

(c) Provide the right to appeal if the person is dissatisfied with the decision (see part 260 of this chapter).

(Approved by the Office of Management and Budget under control numbers 3220–0030, 3220–0031 and 3220–0042)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987]

Subpart B—Applications

§ 217.5 When an application is a claim for an annuity or lump sum.

An application is a claim for an annuity or lump sum if it meets all of the following conditions:

(a) It is on an application form completed and filed with the Board as described in § 217.6;

(b) It is signed by the claimant or by someone described in § 217.17 who can sign the application for the claimant;

(c) It is filed with the Board on or before the date of death of the claimant. (See § 217.10 for limited exceptions.)

(Approved by the Office of Management and Budget under control number 3220–0002)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987]

§ 217.6 What is an application filed with the Board.

(a) *General.* An application filed with the Board is generally one that is filed on a form set up by the Board for that purpose. See part 200 of this chapter for a list of application forms.

(b) *Claim filed with the Social Security Administration.* An application filed for benefits under title II of the Social Security Act on one of the forms set up by the Social Security Administration for that purpose (except an application for a disability insurance benefit that terminated before the employee completed his or her 120th month of creditable railroad service) is also considered an application for an annuity or lump sum if it is filed as shown in § 217.7.

(c) *Claim filed with the Veterans Administration.* An application filed with the Veterans Administration on one of its forms for survivor benefits under section 3005 of title 38, United States Code, is also considered an application for a survivor annuity.

§ 217.7 Claim filed with the Social Security Administration.

(a) *Claim is for life benefits.* An application for life benefits under title II of the Social Security Act is an application for an annuity if the conditions either in paragraphs (a)(1), (2), and (3) or in paragraph (a)(4) of this section are met:

(1) The application was filed because the applicant did not know he or she was eligible for an annuity under the Railroad Retirement Act. The Board must have or receive evidence indicating why the applicant thought that he or she lacked eligibility for an annuity.

(2) The claimant would have been entitled to and would currently be entitled to an annuity under subpart B or D of part 216 of this chapter if the applicant had applied for the annuity on the date the social security application was filed.

(3) The applicant asks the Board in a written statement to consider the application for social security benefits as an application for an employee or spouse annuity.

(4) The application was filed because the employee had less than 10 years of creditable railroad service, and having established entitlement to social security benefits and continued working in railroad service, subsequently acquired 10 years of railroad service.

(b) *Claim is for death benefits.* An application for death benefits under title II of the Social Security Act is an application for an annuity or lump sum if—

(1) The application is filed based on the death of an employee and the Board has jurisdiction for the payment of survivor benefits based on the compensation record of the deceased employee; and

(2) The claimant is eligible for an annuity or a lump-sum death payment on the date the application is filed.

§ 217.8 When one application satisfies the filing requirement for other benefits.

An annuity application filed with the Board is generally considered as an application for other benefits to which a person is or may be eligible. Therefore a claimant does not need to file another application to be entitled to any of the following types of benefits:

(a) An employee age annuity if—

(1) The employee's application for a disability annuity is denied and the employee is eligible for the age annuity on the date the application is filed; or

(2) The employee is entitled to a disability annuity in the month before the month he or she is 65 years old.

(b) An employee disability annuity if an application for an age annuity is denied and the employee is eligible for the disability annuity on the date the application is filed.

(c) An accrued employee or supplemental annuity, or a residual lump sum, if a claimant is eligible for one of these payments when he or she files an

application for a survivor annuity or lump-sum payment under this chapter.

(d) A widow(er)'s annuity if the widow(er) was entitled to a spouse annuity in the month before the month the employee died.

(e) A widow(er)'s annuity if the widow(er) was included in the computation of the employee's annuity under the social security overall minimum provision of the Railroad Retirement Act in the month before the month the employee died.

(f) A child's annuity if the spouse of the employee had the child ''in care'' and was entitled to a spouse annuity in the month before the month the employee died.

(g) A child's annuity or child's full-time student annuity if the child of the employee was included in the computation of the employee's annuity under the social security overall minimum provision of the Railroad Retirement Act in the month before the month the employee died.

(h) A widow(er)'s annuity based on age if the widow(er) was entitled to a widow(er)'s annuity based on disability in the month before the month in which he or she attains age 60.

(i) A widow(er)'s annuity based on age or disability if a widow(er), who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an age or disability annuity when he or she no longer has an eligible child ''in care''.

(j) A spouse annuity based on age if a spouse, who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an unreduced age annuity when he or she no longer has an eligible child ''in care''.

(k) A widow(er)'s annuity based upon having the employee's child ''in care'' if during the time the widow(er) is entitled to an annuity based on disability, he or she has ''in care'' a child of the deceased employee.

(l) A divorced spouse annuity if the divorced spouse was entitled to a spouse annuity reduced for age in the month before the month of the effective date of the final decree of divorce.

(m) A divorced spouse annuity if the spouse claimant has remarried the employee during the six-month retroactive period of the spouse annuity application.

(n) A divorced spouse annuity if the divorced spouse was entitled to a spouse annuity not reduced for age in the month before the month of the effective date of the final decree of divorce and would also be entitled to a divorced spouse annuity not reduced for age.

(o) A surviving divorced spouse annuity if the surviving divorced spouse was entitled to a divorced spouse annuity in the month before the month the employee died.

(p) A remarried widow(er)'s annuity if the remarried widow(er) was entitled to a widow(er)'s annuity in the month before the month of remarriage.

(q) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age or disability if the remarried widow(er) or surviving divorced spouse, who was receiving an annuity because he or she had the employee's child ''in care'', is eligible for an age or disability annuity when he or she no longer has an eligible child ''in care''.

(r) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age if the remarried widow(er) or the surviving divorced spouse was entitled to an annuity based on the disability in the month before the month in which he or she attains age 65.

(s) A remarried widow(er)'s annuity or a surviving divorced spouse annuity based on age if the remarried widow(er) or surviving divorced spouse, who was receiving an annuity based on disability, is 60 years old or older when he or she recovers from the disability.

(t) A benefit under title II of the Social Security Act unless the applicant restricts the application only to an annuity payable under the Railroad Retirement Act.

(u) An accrued annuity due at the death of a spouse or divorced spouse if the claimant is entitled to an employee annuity on the same claim number.

(v) A full-time student's annuity if the student was entitled to a child's annuity in the month before the month the child attained age 18.

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13363, Apr. 3, 1989; 60 FR 21982, May 4, 1995; 66 FR 27454, May 17, 2001]

§ 217.9 Effective period of application.

(a) *When effective period ends.* The effective period of an application ends on the date of the notice of an initial decision denying the claim. If a timely appeal is made (see part 260 of this chapter) the effective period of the application ends on the date of the notice of the decision of the referee, on the date of the notice of the final decision of the Board, or when court review of the denial has been completed. After the effective period of an application ends, the person must file a new application for any annuity or lump sum to which the claimant believes he or she is eligible.

(b) *Application filed before claimant is eligible*—(1) *General rule.* Except as shown in paragraph (b)(2) and paragraph (b)(3) of this section, an application for an annuity must be denied if it is filed with the Board more than three months before the date an annuity can begin.

(2) *Application for disability annuity.* If the Board determines that a claimant for a disability annuity is disabled under part 220 of this chapter, beginning with a date after the application is filed and before a final decision is made, the application is treated as though it were filed on the date the claimant became disabled. The claimant may be an employee, widow(er), surviving divorced spouse, remarried widow(er), or surviving child.

(3) *Application for spouse annuity filed simultaneously with employee disability annuity application.* When the qualifying employee's annuity application effective period is determined by the preceding paragraph (b)(2) of this section, a spouse who meets all eligibility requirements may file an annuity application on the same date as the employee claimant. The spouse application will be treated as though it were filed on the later of the actual filing date or the employee's annuity beginning date.

(c) *Application filed after the claimant is eligible*—(1) *Application for lump-sum death payment.* An application for a lump-sum death payment under part 234 of this chapter must be filed within two years after the death of the employee. This period may be extended under the Soldiers' and Sailors' Civil Relief Act of 1940, or when the applicant can prove ''good cause'' under § 217.11 of this chapter for not filing within the time limit.

(2) *Application for annuity unpaid at death.* An application for an annuity due but unpaid at death under part 234 of this chapter must be filed within two years after the death of the person entitled to the annuity. This period may be extended under the Soldiers' and Sailors' Civil Relief Act of 1940, or when the applicant can prove ''good cause'' under § 217.11 of this chapter for not filing within the time limit.

(3) *Application for residual lump sum.* An application for a residual lump sum under part 234 of this chapter may be filed at any time after the death of the employee.

(4) *Application for a period of disability.* In order to be entitled to a period of disability under part 220 of this chapter, an employee must apply while he or she is disabled under part 220 or not later than 12 months after the month in which the period of disability ends except that an employee who is unable to apply within the 12-month period after the period of disability ends because his or her physical condition limited his or her activities to the extent that he or she could not complete and sign an application or because he or she was mentally incompetent, may apply no later than 36 months after the period of disability ends.

(Approved by the Office of Management and Budget under control number 3220–0002)

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13363, Apr. 3, 1989; 67 FR 42714, June 25, 2002]

§ 217.10 Application filed after death.

(a) A survivor eligible for an annuity or lump sum under this chapter may file an application to establish a period of disability if the employee dies before filing an application for a disability annuity. A period of disability is defined in part 220 of this chapter. The application must be filed within three months after the month the employee died.

(b) A person who could receive payment for the estate of a person who paid the burial expenses of the deceased employee may file an application if the person who paid the burial

expenses dies before applying for the lump-sum death payment under part 234 of this chapter. The application must be filed within the two-year period shown in § 217.9 (c)(1).

(c) A widow(er) or surviving divorced spouse may file an application for a spouse or divorced spouse annuity after the death of the employee if the widower(er) or surviving divorced spouse was eligible for a spouse or divorced spouse annuity in any month before the month the employee died. The spouse or divorced spouse annuity is payable from the beginning date set forth in part 218 of this chapter.

(Approved by the Office of Management and Budget under control numbers 3220–0031 and 3220–0032)

[47 FR 7647, Feb. 22, 1982, as amended at 52 FR 11017, Apr. 6, 1987; 54 FR 13364, Apr. 3, 1989]

§ 217.11 "Good cause" for delay in filing application.

(a) An applicant has ''good cause'' for a delay in the filing of an application for a lump-sum death payment or an annuity unpaid at death, as shown in § 217.9(c)(1) and (2), if the delay was due to—

(1) Circumstances beyond the applicant's control, such as extended illiness, mental or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished by the Board; or

(3) Efforts by the applicant to secure evidence without realizing that evidence could be submitted after filing an application; or

(4) Unusual or unavoidable circumstances which show that the applicant could not reasonably be expected to have been aware of the need to file an application within the set time limit.

(b) An applicant does not have good cause for a delay in filing if he or she was informed of the need to file within the set time limit but neglected to do so or decided not to file.

Subpart C—Filing An Application

§ 217.15 Where to file.

(a) *Applicant in U.S. or Canada.* An applicant who lives in the United States or Canada may file an application at any Board office in person or by mail. An applicant may also give the application to any Board field employee who is authorized to receive it at a place other than a Board office.

(b) *Application outside U.S.* An applicant who lives outside the United States or Canada may file an application at any United States Foreign Service office. An applicant may also send the application to an office of the Board.

§ 217.16 Filing date.

An application filed in a manner and form acceptable to the Board is officially filed with the Board on the earliest of the following dates:

(a) On the date it is received at a Board office.

(b) On the date it is delivered to a field employee of the Board as described in § 217.15.

(c) On the date it is received at any office of the U.S. Foreign Service.

(d) On the date the application was mailed, as shown by the postmark, if using the date it is received will result in the loss or reduction of benefits.

(e) On the date the Social Security Administration considers the application filed, if it is filed with the Social Security Adminstration or the Veterans Administration.

§ 217.17 Who may sign an application.

An application may be signed according to the following rules:

(a) A claimant who is 18 years old or older, competent (able to handle his or her own affairs), and physically able to sign the application, must sign in his or her own handwriting, except as provided in paragraph (e) of this section. A parent or a person standing in place of a parent must sign the application for a child who is not yet 18 years old, except as shown in paragraph (d) of this section.

(b) A claimant who is unable to write must make his or her mark. A Board representative or two other persons must sign as witnesses to a signature by mark.

(c) A claimant's representative, as described in part 266 of this chapter, must sign the application if the claimant is incompetent (unable to handle his or her own affairs).

(d) A claimant who is a child between the ages of 16 and 18, is competent, as defined in paragraph (a) of this section, has no court appointed representative, and is not in the care of any person, may sign the application.

(e) If it is necessary to protect a claimant from losing benefits and there is good cause for the claimant not personally signing the application, the Board may accept an application signed by someone other than a person described in paragraphs (a), (b), (c), and (d) of this section. A person who signs an application for someone else will be required to provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court-appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court-appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for the care of the claimant, he or she must submit a statement indicating the person's position of responsibility at the institution.

(4) The Board may, at any time, in its sole discretion require additional evidence to establish the authority of a person to sign an application for someone else.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030, 3220–0031 and 3220–0042)

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13364, Apr. 3, 1989]

§ 217.18 When application is not acceptable.

(a) *Not properly signed.* The Board will ask the applicant to prepare a corrected application if—

(1) The original application was signed by someone other than the claimant or a person described in § 217.17; or

(2) The signature has been changed; or

(3) The signature is not readable or does not appear to be authentic.

(b) *Incomplete or not readable.* The Board will ask the applicant to prepare a supplemental application with certain items completed if—

(1) Any entries on the application are not readable or appear to be incorrect; or

(2) An important part of the application was not completed.

(c) *Obtaining corrected application.* If an application is not properly signed, the applicant must prepare a new application with a corrected signature. If the Board receives the corrected application within 30 days after the applicant is asked to prepare it, the Board will use the filing date of the original application to pay benefits. If the Board receives the corrected application more than 30 days after the notice to the applicant, the Board will use the filing date of the corrected application to pay benefits.

§ 217.19 Representative of the claimant selected after application is filed.

(a) *Before benefits awarded.* If the Board selects a representative for an incompetent claimant (see part 266 of this chapter) after an application is filed but before the benefit is awarded, a new benefit application must be filed by the representative. However, benefits will be paid using the filing date of the original benefit application.

(b) *After benefits awarded.* If the Board selects a representative after a monthly annuity was awarded to another person, the representative must apply as a substitute payee on a form specifically designed for that purpose. A new annuity application is not required.

§ 217.20 When a written statement is used to establish the filing date.

(a) *Statement filed with the Board.* A written statement indicating an intent to file a claim for an annuity or lump sum, filed with the Board as provided in §§ 217.15 and 217.16, can establish the filing date of an application. A form set up by the Board to obtain information about persons who may be eligible for an annuity or lump sum in a particular

case is not by itself considered a written statement for the purpose of this section. The Board will use the filing date of the written statement if all of the following requirements are met:

(1) The statement gives a person's clear and positive intent to claim an annuity or lump sum for himself or herself or for some other person.

(2) The claimant or a person described in § 217.17 signs the statement.

(3) The person who signed the statement files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application.

(4) The claimant is alive when the application is filed except as provided in § 217.10.

(b) *Statement filed with the Social Security Administration.* A written statement filed with the Social Security Administration can be used to establish the filing date of an application if, assuming the statement were an application, the conditions under § 217.7 are met and—

(1) The statement gives a clear and positive intent to claim benefits under title II of the Social Security Act;

(2) The claimant or a person described in § 217.17 signs the statement;

(3) The statement is sent to the Board by the Social Security Administration;

(4) The person who signed the statement files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application; and

(5) The claimant is alive when the application is filed except as provided in § 217.10.

(c) *Telephone contact with the Board.* If an individual telephones a Board office and advises a Board employee that he or she intends to file an application but cannot do so before the end of the month, the Board employee will prepare and sign a written statement which may be used to establish the filing date of an application if all of the following requirements are met:

(1) The inquirer expresses a clear and positive intent to claim benefits for himself or herself or for some other person;

(2) The prescribed application cannot be filed by the end of the current month;

(3) The inquirer is either the potential claimant or the person who will file an application as representative payee therefor;

(4) The inquiry is received by an office of the Board no more than 3 months before eligibility exists;

(5) It appears that a loss of benefits might otherwise result;

(6) The telephone inquirer files an application with the Board on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application; and

(7) The claimant is alive when the application is filed, except as provided in § 217.10 of the part.

[47 FR 7647, Feb. 22, 1982, as amended at 54 FR 13364, Apr. 3, 1989]

§ 217.21 Deterred from filing.

A person who telephones or visits a Board office stating that he or she wishes to file for an annuity or lump sum, but puts off filing because of an action or lack of action by an employee of the Board, can establish a filing date based on that oral notice if the following conditions are met:

(a) There is evidence which establishes that the employee of the Board failed to—

(1) Tell the person that it was necessary to file an application on the proper form; or

(2) Tell the person that a written statement could protect the filing date; or

(3) Give the person the proper application form; or

(4) Correctly inform the person of his or her eligibility.

(b) The person files an application on one of the forms described in part 200 of this chapter within 90 days after the date a notice is sent advising the person of the need to file an application.

(c) The claimant is alive when the application is filed except as provided in § 217.10.

Subpart D—Cancellation of Application

§ 217.25 Who may cancel an application.

An application may be cancelled by the claimant or a person described in § 217.17. If the claimant is deceased, the person who is or could be eligible for any annuity accrual under part 234 of this chapter may cancel the application for the annuity.

§ 217.26 How to cancel an application.

An application may be cancelled under the following conditions:

(a) *Before an annuity is awarded.* The application may be cancelled if—

(1) The applicant files a written request with the Board at a place described in § 217.15 asking that the application be cancelled or stating that he or she wants to withdraw the application;

(2) The claimant is alive on the date the written request is filed or the claimant is deceased and the rights of no person other than the person requesting the cancellation will be adversely affected; and

(3) The applicant files the written request on or before the date the annuity is awarded.

(b) *After an annuity is awarded.* The application may be cancelled if—

(1) The conditions in paragraph (a)(1) and (2) of this section are met;

(2) Any other person who would lose benefits because of the cancellation consents to the cancellation in writing; and

(3) All annuity payments already made based on the application being cancelled are repaid or will be recovered.

§ 217.27 Effect of cancellation.

When a person cancels an application the effect is the same as though an application was never filed. When an employee cancels his or her application, any application filed by the employee's spouse is also cancelled. However, a request to cancel a survivor's application will cancel only the application of the survivor named in the written request. A person who cancels an application may reapply by filing a new application under this part.

Subpart E—Denial of Application

§ 217.30 Reasons for denial of application.

The Board will deny each application filed by or for an employee, spouse or survivor for one or more of the following reasons:

(a) The claimant does not meet the eligibility requirements for an annuity or lump sum under this chapter.

(b) The applicant does not submit the evidence required under this chapter to establish eligibility for an annuity or lump sum.

(c) The applicant files an application more than three months before the date on which the eligible person's benefit can begin except if the application is for an employee disability annuity or for a spouse annuity filed simultaneously with the employee's disability annuity application.

[47 FR 7647, Feb. 22, 1982, as amended at 67 FR 42714, June 25, 2002]

§ 217.31 Applicant's right to appeal denial.

Each applicant is given the right to appeal the denial of his or her application if he or she does not agree with the Board's decision. The appeals process is explained in part 260 of this chapter.

PART 218—ANNUITY BEGINNING AND ENDING DATES

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218.44 When a remarried widow(er) annuity ends.

AUTHORITY: 45 U.S.C. 231f(b)(5).

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Subpart A—General

§ 218.1 Introduction.

This part tells when a person's entitlement to a monthly railroad retirement annuity begins and ends. Ordinarily, an annuity begins on the earliest date permitted under the Railroad Retirement Act (Act). This part also tells when and how a person may select a later beginning date. Included is an explanation of how work and certain types of special payments affect the beginning date of an employee or spouse annuity.

§ 218.2 Definitions.

As used in this part:

Applicant means a person who signs an application for an annuity for himself, herself or for some other person.

Application means a form described in part 217 of this chapter.

Award means to process a form to make a payment.

Claimant means the person for whom an annuity application is filed.

Filing date means the date on which an application or written statement is filed with the Board.

Tier I benefit means the benefit calculated using the Social Security formulas and is based upon earnings, both in and outside the railroad industry.

Tier II benefit means the benefit calculated under a formula found in the Act and is based only upon railroad earnings.

§ 218.3 When an employee disappears.

(a) *General.* If an employee who is entitled to an annuity disappears, the employee annuity ends on the last day of the month before the month of the disappearance.

(b) *Employee has a current connection.* (1) The Board may pay survivor benefits from the month of the employee's disappearance if both of the following conditions are met at the time of the disappearance:

(i) The employee has a current connection with the railroad industry as defined in part 216 of this chapter, and

(ii) The employee's spouse is entitled, or would have been entitled if he or she had filed an application, to a spouse annuity in the month that the employee disappeared.

(2) If the employee is later found to have been alive during any month for which a survivor annuity was paid, the amount of any incorrect payment must be recovered under the rules of part 255, Erroneous Payments, of this chapter. The incorrect payment is the amount of any survivor benefits which were paid minus any spouse benefits which were paid minus any spouse benefits that would have been paid.

(c) *Employee has no current connection.* If the employee does not have a current connection and the employee's spouse is entitled to an annuity in the month of the employee's disappearance, the spouse annuity will continue to be paid until one of the following events occurs:

(1) The employee's death is established.

(2) The spouse annuity ends for another reason.

Subpart B—When an Annuity Begins

§ 218.5 General rules.

(a) An annuity begins either on the earliest date permitted by law, or on a specific date chosen by the applicant. If the applicant chooses a specific date, that date must not be before the earliest date permitted by law.

(b) An annuity may not begin on the thirty-first day of a month, unless the claimant would lose benefits if the annuity begins on the first day of the following month. No annuity is payable for the thirty-first day of any month.

§ 218.6 How to choose an annuity beginning date.

(a) *When application is filed.* The applicant may choose an annuity beginning date by—

(1) Naming the month, day and year in an application accepted by the Board; or

(2) Including with the application a signed statement which tells the date (month, day and year) when the annuity should begin.

(b) *After application is filed.* After an application is filed, the claimant may choose an annuity beginning date by submitting a signed statement which tells the month, day and year when the annuity should begin.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030 and 3220–0042)

§ 218.7 When chosen annuity beginning date is more than three months after filing date.

If the applicant for any type of annuity other than a disability annuity, or a spouse annuity based upon the disabled applicant's compensation, chooses an annuity beginning date in a month which is more than three months after the date the application is filed, the Board will deny the application as explained in part 217 of this chapter. The applicant must file a new application no earlier than three months before the month he or she wants the annuity to begin.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030 and 3220–0042)

§ 218.8 When an individual may change the annuity beginning date.

(a) *Before annuity is awarded.* A claimant may change the annuity beginning date if—

(1) The claimant requests the change in a signed statement; and

(2) The statement is received by the Board on or before the date of the claimant's death.

(b) *After annuity is awarded.* An award can be reopened to change the annuity beginning date to a later date if—

(1) The annuitant requests the change in a signed statement;

(2) The statement is received by the Board on or before the date of the annuitant's death;

(3) The annuitant shows that it is to his or her advantage to have a later annuity beginning date; and

(4) All payments made for the period before the later annuity beginning date are recovered by cash refund or setoff.

§ 218.9 When an employee annuity begins.

(a) *Full-age annuity*—employee has completed 10 years but less than 30 years of service. An employee full-age annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the month in which the claimant attains full retirement age; or

(3) The first day of the sixth month before the month in which the application is filed.

(b) *Reduced-age annuity*—employee has completed 10 years but less than 30 years of service. An employee reduced-age annuity begins on the later of either the date chosen by the applicant, or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the first full month in which the claimant is age 62; or

(3) The first day of the month in which the application is filed if the claimant does not have a spouse (or divorced spouse) who would be entitled to a retroactive unreduced spouse (or divorced spouse) annuity. If the claimant has such a spouse (or divorced spouse) the claimant's annuity can begin on the first day of the month in which the spouse (or divorced spouse) annuity begins.

(c) *Disability annuity.* An employee disability annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the twelfth month before the month in which the application is filed;

(3) The first day of the sixth month after the month of disability onset; or

(4) The first day of the month of disability onset if the claimant was previously entitled to an employee disability annuity which ended within five years of the current disability onset month.

(d) *Annuity based on at least 30 years of service.* An employee annuity based on at least 30 years of service begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(1) The day after the day the claimant last worked for a railroad employer;

(2) The first day of the first full month in which the claimant is age 60 and will accept a reduced annuity;

(3) The first day of the month in which the claimant attains age 62; or

(4) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.10 When a supplemental annuity begins.

An employee supplemental annuity begins on the latest of—

(a) The beginning date of the employee age or disability annuity;

(b) The first day of the month in which the employee meets the age and years of service requirements as shown in part 216 of this chapter; or

(c) The first day of the twelfth month before the month in which the employee disability annuitant under age 65 gives up the right to return to work as explained in part 216 of this chapter.

§ 218.11 When a spouse annuity begins.

(a) A spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the latest of—

(i) The day after the day the claimant last worked for a railroad employer;

(ii) The beginning date of the employee annuity;

(iii) The first day of the month in which the claimant meets the marriage requirement as shown in part 216 of this chapter; or

(iv) The first day of the month in which the employee annuitant meets the age requirement to qualify the claimant as shown in part 216 of this chapter.

(2) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant meets the age requirement as shown in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant becomes eligible for a spouse annuity based on having a ''child in care'' as shown in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

(4) *Reduced-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the first full month in which the spouse is age 62 if the employee has less than 30 years of service;

(iii) The first day of the month in which the spouse is age 60, if the employee has at least 30 years of service;

(iv) The first day of the sixth month before the month in which the application is filed; or

(v) The first day of the month in which the application is filed if beginning the annuity in an earlier month would increase the age reduction factor applied to the annuity.

§ 218.12 When a divorced spouse annuity begins.

(a) A divorced spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the latest of—

(i) The day after the day the claimant last worked for a railroad employer;

(ii) The beginning date of the employee annuity;

(iii) The first day of the first full month in which the employee annuitant is age 62 if the employee has not been granted a period of disability;

(iv) The first day of the month in which the employee annuitant attains age 62 if the employee has been granted a period of disability; or

(v) The first day of the month in which the final decree of divorce is effective.

(2) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age;

(iii) The first day of the twelfth month before the month in which the application is filed if the employee is a disability annuitant or has been granted a period of disability; or

(iv) The first day of the sixth full month before the month in which the application is filed if the employee is not entitled to a disability annuity or a period of disability.

(3) *Reduced-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the first full month the claimant is age 62 if the application is filed in or before that month; or

(iii) The first day of the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.13 When a widow(er) annuity begins.

(a) A widow(er) annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(2) *Reduced-age annuity*—(i) *Widow(er) age 60 through age 62.* The earliest date permitted by law is the latest of—

(A) The first day of the month in which the employee dies;

(B) The first day of the month in which the claimant attains age 60; or

(C) The first day of the sixth month before the month in which the application is filed.

(ii) *Widow(er) over age 62 but under full retirement age.* The earliest date permitted by law is the latest of—

(A) The first day of the month in which the employee dies;

(B) The first day of the month in which the claimant attains age 62 and one month; or

(C) The first day of the month in which the application is filed.

(3) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(4) *''Child in care'' annuity*. The earliest date permitted by law is the latest of—

(i) The first day of the month in which the employee dies;

(ii) The first day of the month in which the claimant becomes eligible for a widow(er) annuity based on having a ''child in care'' as explained in part 216 of this chapter; or

(iii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.14 When a child annuity begins.

(a) A child annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules*. The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a child annuity as explained in part 216 of this chapter.

(2) *Child age annuity*. The earliest date permitted by law is the later of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

(3) *Child annuity based on full-time school attendance*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the sixth month before the month in which the application is filed;

(iii) The first day of the month in which the claimant is in full-time school attendance at an elementary or secondary educational institution; or

(iv) The first day of the month in which the claimant attains age 18.

(4) *Child disability annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the sixth month before the month in which the application is filed;

(iii) The first day of the month in which the claimant meets the definition of disability as explained in part 220; or

(iv) The first day of the month in which the claimant attains age 18.

§ 218.15 When a parent annuity begins.

A parent annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law. The earliest date permitted by law is the latest of—

(a) The first day of the month in which the employee dies;

(b) The first day of the month in which the claimant attains age 60; or

(c) The first day of the sixth month before the month in which the application is filed.

§ 218.16 When a surviving divorced spouse annuity begins.

(a) A surviving divorced spouse annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules*. The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a surviving divorced spouse annuity as shown in part 216 of this chapter.

(2) *Full-age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *Reduced age annuity*. The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 60; or

(iii) The first day of the month in which the application is filed or the

first day of the month preceding the month in which the application is filed if the employee died in that preceding month.

(4) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(5) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.17 When a remarried widow(er) annuity begins.

(a) A remarried widow(er) annuity begins on the later of either the date chosen by the applicant or the earliest date permitted by law.

(b) *Earliest date permitted by law*—(1) *General rules.* The earliest date permitted by law is the later of—

(i) The first day of the month in which the employee dies; or

(ii) The first day of the month in which the claimant becomes eligible for a remarried widow(er) annuity as shown in part 216 of this chapter.

(2) *Full-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains full retirement age; or

(iii) The first day of the sixth month before the month in which the application is filed.

(3) *Reduced-age annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 60: or

(iii) The first day of the month in which the application is filed or the first day of the month preceding the month in which the application is filed if the employee died in that preceding month.

(4) *Disability annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section;

(ii) The first day of the month in which the claimant attains age 50;

(iii) The first day of the twelfth month before the month in which the application is filed; or

(iv) The first day of the sixth month after the month of disability onset.

(5) *''Child in care'' annuity.* The earliest date permitted by law is the latest of—

(i) The month shown in paragraph (b)(1) of this section; or

(ii) The first day of the sixth month before the month in which the application is filed.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

Subpart C—How Work and Special Payments Affect an Employee, Spouse, or Divorced Spouse Annuity Beginning Date

§ 218.25 Introduction.

The rules in this subpart apply only to an employee, spouse, divorced spouse, and supplemental annuity. They do not apply to any type of survivor annuity.

§ 218.26 Work started after annuity beginning date.

(a) *General.* An annuity can begin only after an employee, spouse, or divorced spouse stops any work for a railroad employer. However, if the employee, spouse or divorced spouse starts work after an ''intent to retire'' is established, that work will have no effect on the annuity beginning date. However, an annuity cannot be paid for any month the employee, spouse or divorced spouse returns to work for a railroad employer.

(b) *Intent to retire*—(1) *Disability annuity.* An ''intent to retire'' is established to pay a disability annuity when—

(i) The employee files for a disability annuity; or

(ii) The employee gives up all rights to return to work for a railroad employee before starting any new work.

(2) *Age annuity.* An ''intent to retire'' is established to pay an employee age, spouse or divorced spouse annuity when the employee, spouse or divorced spouse gives up all rights to return to work for a railroad employer before starting any new work.

§ 218.27 Vacation pay.

(a) *From railroad employer.* Vacation pay may be credited to the vacation period due the employee or to the last day of actual work for the railroad employer. If the vacation pay is credited to the vacation period, the annuity can begin no earlier than the day after the vacation period ends. (Part 211 of this chapter discusses how vacation pay is credited as compensation.)

(b) *From non-railroad employer.* Vacation pay will not affect the annuity beginning date.

§ 218.28 Sick pay.

(a) *From railroad employer.* If the employee is carried on the payroll while sick, the annuity can begin no earlier than the day after the last day of sick pay. However, sick pay is not considered compensation and does not affect the annuity beginning date if it is a payment described in §211.2(c)(6) of these regulations.

(b) *From non-railroad employer.* Sick pay will not affect the annuity beginning date.

§ 218.29 Pay for time lost.

Pay for time lost because of personal injury must be credited to an actual period of time lost. The annuity can begin no earlier than the day after that period ends.

§ 218.30 Separation, displacement or dismissal allowance.

(a) *General.* When an employee receives a separation, displacement or dismissal allowance from a railroad employer, the annuity beginning date depends on whether the payments are a separation allowance as described in paragraph (b) of this section, or monthly compensation payments as described in paragraph (c) of this section. (Part 211 of this chapter discusses how a separation, displacement or dismissal alowance is credited as compensation.)

(b) *Separation allowance.* When an employee accepts a separation allowance, the employee gives up his or her job rights. Regardless of whether a separation allowance is paid in a lump sum or in installments, the annuity can begin as early as the day after the day the separation allowance is credited.

(c) *Monthly compensation payments.* An employee who receives monthly compensation payments keeps his or her job rights while the payments are being made. The annuity cannot begin until after the end of the period for which payments are made.

Subpart D—When an Annuity Ends

§ 218.35 When an employee age annuity ends.

An employee annuity based on age ends with the last day of the month before the month in which the employee dies.

§ 218.36 When an employee disability annuity ends.

(a) *Ending date.* An employee annuity based on disability ends with the earliest of—

(1) The last day of the month before the month in which the employee dies;

(2) The last day of the second month following the month in which the employee's disability ends; or

(3) The last day of the month before the month in which the employee attains full retirement age (the disability annuity is changed to an age annuity).

(b) *Effect of ended disability annuity on eligibility for a later annuity.* The ending of a disability annuity will not affect an employee's rights to receive any annuity to which he or she later becomes entitled. When a disability annuity ends before an employee attains full retirement age, any additional railroad service the employee has after the disability annuity ends can be credited as if no annuity had previously been paid.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.37 When a supplemental annuity ends.

A supplemental annuity ends when the employee age or disability annuity ends.

§ 218.38 When a spouse annuity ends.

(a) *General rules.* A spouse annuity ends with the earliest of—

(1) The last day of the month before the month in which the spouse dies;

(2) The last day of the month before the month in which the employee dies or the employee's entitlement to an annuity ends;

(3) The last day of the month before the month in which the spouse's marriage to the empoyee is ended by absolute divorce, annulment, or other judicial action (the spouse may be entitled to a divorced spouse annuity as explained in part 216 of this chapter); or

(4) The month shown in paragraphs (b) and (d) of this section.

(b) *Annuity entitlement based on ''child in care.''* A spouse annuity based on having a ''child in care'' ends as shown in this paragraph if he or she is not also eligible for a full-age spouse annuity as explained in part 216 of this chapter. However, see also paragraph (c) of this section. If the spouse is eligible for a full-age spouse annuity when he or she is no longer entitled on the basis of a child, his or her annuity is changed to a spouse annuity based on age. A spouse annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (d) of this section;

(2) The last day of the month before the month in which the child is no longer in the spouse's care, as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 18 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

(c) *Tier I benefit entitlement based on ''child in care.''* The tier I benefit of a spouse entitled because he or she has a ''child in care'' and is not otherwise entitled to a tier I benefit based on age, ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (d) of this section;

(2) The last day of the month before the month in which the child is no longer in the spouse's care as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 16 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 16.

(d) *Entitlement based on deemed marriage.* If the spouse entitlement is based on a deemed valid marriage, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraphs (a) and (b) of this section;

(2) The last day of the month before the month in which the deemed spouse enters a valid marriage with someone other than the employee; or

(3) The last day of the month before the month in which the Board approves an award to someone else as the employee's legal spouse.

§ 218.39 When a divorced spouse annuity ends.

A divorced spouse annuity ends with the earliest of the last day of the month before the month in which the—

(a) Divorced spouse dies;

(b) Employee's entitlement to an annuity ends;

(c) Divorced spouse marries;

(d) Employee dies; or

(e) Divorced spouse becomes entitled to a retirement or disability insurance benefit under the Social Security Act based on a primary insurance amount which equals or exceeds the amount of the full divorced spouse annuity before reduction for age.

§ 218.40 When a widow(er) annuity ends.

(a) *Entitlement based on age.* When a widow(er)'s annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which—

(1) The widow(er) dies;

(2) The widow(er) remarries (the widow(er) may be entitled to benefits as a remarried widow(er) as explained in part 216 of this chapter);

(3) The widow(er) becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity; or

(4) The Board approves an award to someone else as the employee's legal widow(er) if entitlement is based on a deemed valid marriage.

(b) *Disabled widow(er).* If entitlement is based on the widow(er)'s disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the widow(er) attains age 60 (the disability annuitant then becomes entitled to an annuity based upon age).

(c) *Annuity entitlement based on ''child in care.''* A widow(er) annuity based on having a ''child in care'' ends as shown in this paragraph if he or she is not eligible for a widow(er) annuity based on age as explained in part 216 of this chapter. However, see also paragraph (d) of this section. If the widow(er) is eligible for a widow(er) annuity based on age, when he or she is no longer entitled on the basis of having a ''child in care,'' his or her annuity is changed to a widow(er) annuity based on age. A widow(er) annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the widow(er)'s care as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate, but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 18 and is not disabled;

(4) The last day of the month before the month in which the widow(er) attains full retirement age (the ''child in care'' annuity is changed to an age annuity);

(5) The last day of the month before the month in which the child marries;

(6) The last day of the month before the month in which the child dies; or

(7) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

(d) *Tier I benefit entitlement based on child in care.* The tier I benefit of a widow(er), entitled because he or she has a ''child in care'' and is not otherwise entitled to a tier I benefit based on age, ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the widow(er)'s care as explained in part 216 of this chapter;

(3) The last day of the month before the month in which the child attains age 16 and is not disabled;

(4) The last day of the month before the month in which the child marries;

(5) The last day of the month before the month in which the child dies; or

(6) The last day of the second month after the month in which the child's disability ends, if the child is over age 16.

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.41 When a child annuity ends.

A child annuity ends with the earliest of—

(a) The last day of the month before the month in which the child marries;

(b) The last day of the month before the month in which the child dies;

(c) The last day of the month before the month in which the child attains age 18 if the child is not eligible for an annuity as a disabled or student child;

(d) The last day of the last month in which the child is considered a full-time student, as defined in part 216 of this chapter, if the child is a full-time student age 18 through 19; or

(e) The last day of the second month after the month in which the child's disability ends, if the child is over age 18.

§ 218.42 When a parent annuity ends.

(a) *Tier I.* The tier I benefit of a parent annuity ends with the earliest of the last day of the month before the month in which the parent—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the tier I benefit of the parent annuity before any reduction for the family maximum, unless he or she is also entitled to a tier II benefit (reduction for the family maximum is discussed in part 228 of this chapter);

(3) Becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity; or

(4) Remarries after the employee's death, unless he or she marries a person who is entitled to Social Security or Railroad Retirement Act benefits as a divorced spouse, widow, widower, mother, father, parent, or disabled child.

(b) *Tier II.* The tier II benefit of a parent annuity ends with the earliest of the last day of the month before the month in which the parent—

(1) Dies;

(2) Remarries after the employee's death; or

(3) Becomes entitled to another survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

§ 218.43 When a surviving divorced spouse annuity ends.

(a) *Entitlement based on age.* When the surviving divorced spouse annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which the surviving divorced spouse—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the amount of the full surviving divorced spouse annuity before reduction for age; or

(3) Becomes entitled to a spouse or survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

(b) *Entitlement based on disability.* When the surviving divorced spouse annuity is based on disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the surviving divorced spouse attains full retirement age (the disability annuitant then becomes entitled based upon age).

(c) *Entitlement based on ''child in care.''* When the surviving divorced spouse annuity is based on having a ''child in care'' as explained in part 216 of this chapter, the annuity ends as shown in this paragraph unless he or she is at least age 60 and was married to the employee for at least 10 years. In that case, the surviving divorced spouse annuity based on having a child in care is changed to an annuity based on age. If the surviving divorced spouse is not entitled to an annuity based on age, the surviving divorced spouse annuity based on ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the surviving divorced spouse's care, as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate, but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 16, unless the child is disabled;

(4) The last day of the month before the month in which the surviving divorced spouse remarries unless the marriage is to an individual entitled to a retirement, disability, widow(er)'s, father's/mother's, parent's or child's disability benefit under the Railroad Retirement Act or Social Security Act;

(5) The last day of the second month after the month in which the child's disability ends, if the child is over age 16; or

(6) The last day of the month before the month in which the surviving divorced spouse attains full retirement age (the annuitant then becomes entitled to an annuity based upon age).

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 218.44 When a remarried widow(er) annuity ends.

(a) *Entitlement based on age.* When the remarried widow(er) annuity is based on age, the annuity ends with the earliest of the last day of the month before the month in which the remarried widow(er)—

(1) Dies;

(2) Becomes entitled to an old age benefit under the Social Security Act that is equal to or larger than the amount of the full remarried widow(er) annuity before reduction for age or the family maximum (see part 228 of this chapter); or

(3) Becomes entitled to a spouse or survivor annuity in a larger amount, unless he or she elects to be paid the smaller annuity.

(b) *Entitlement based on disability.* When the remarried widow(er) annuity is based on disability, the annuity ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the second month following the month in which the disability ends; or

(3) The last day of the month before the month in which the remarried widow(er) attains full retirement age (the disability annuitant then becomes entitled to an annuity based upon age).

(c) *Entitlement based on ''child in care.''* When the remarried widow(er) annuity is based on having a ''child in care,'' as explained in part 216 of this chapter, the annuity ends as shown in this paragraph unless the remarried widow(er) is at least age 60. In that case, the remarried widow(er) annuity based on having a ''child in care'' is changed to an annuity based on age. If the remarried widow(er) is not entitled to an annuity based on age, the remarried widow(er) annuity based on having a ''child in care'' ends with the earliest of—

(1) The last day of the month shown in paragraph (a) of this section;

(2) The last day of the month before the month in which the child is no longer in the remarried widow(er)'s care, as explained in part 216 of this chapter (in this case entitlement to the annuity does not terminate but no annuity is payable while the child is no longer in care);

(3) The last day of the month before the month in which the child attains age 16, unless the child is disabled;

(4) The last day of the month before the month in which the remarried widow(er) remarries unless the marriage is to an individual entitled to a retirement, disability, widow(er)'s, father's/mother's, parent's or child's disability benefit under the Railroad Retirement Act or Social Security Act;

(5) The last day of the second month after the month in which the child's disability ends, if the child is over age 16; or

(6) The last day of the month before the month in which the remarried widow attains full retirement age (the annuitant then becomes entitled to an annuity based upon age).

[54 FR 30725, July 24, 1989, as amended at 68 FR 39010, July 1, 2003]

PART 219—EVIDENCE REQUIRED FOR PAYMENT

Subpart A—General Evidence Requirements

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Subpart A—General Evidence Requirements

§ 219.1 Introduction.

As described in parts 216 (Eligibility for an Annuity), 234 (Lump-Sum Payments), and 222 (Family Relationships), certain requirements must be met before benefits may be paid under the Railroad Retirement Act. This part contains the basic rules for evidence that is required to support a claimant's claim for monthly or lump-sum benefit payments under the Railroad Retirement Act. Part 219 describes when evidence is required and what types of documents can be used as evidence. Part 222 defines and explains family relationships for which evidence requirements are stated in part 219. Special evidence requirements for disability annuities are found in part 220 of this chapter.

§ 219.2 Definitions.

As used in this subpart—

Annuity means a recurring payment due an entitled person for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Board accepts as an application.

Claimant means the person who files an application for an annuity or lump-sum payment for himself, herself, or some other person.

Benefit means any employee annuity, spouse annuity, survivor annuity, or lump-sum payment under the Railroad Retirement Act.

Convincing evidence means one or more pieces of evidence that proves to the satisfaction of the Board that an individual meets a requirement for eligibility for benefits. See §219.7 for guides the Board uses in deciding whether evidence is convincing.

Eligible means that a person meets all of the requirements for payment of benefits but has not yet applied therefor.

Entitled means that a person has applied for and has proved his or her right to payment of benefits.

Evidence means any record or document or testimony that helps to show whether a person is eligible for benefits. It may also be used to establish

whether the person is still entitled to benefits.

Representative means a person who acts on behalf of a claimant in regard to his or her claim for benefits from the Board and in the presentation of evidence to support the claim.

§ 219.3 When evidence is required.

(a) *To prove initial eligibility.* The Board will ask for evidence to prove a claimant is eligible for benefits when he or she applies for benefits. Usually the Board will ask the claimant to furnish specific kinds of evidence or information by a certain date to prove initial eligibility for benefits. If evidence or information is not received by that date, the Board may decide that the claimant is not eligible for benefits and will deny his or her application.

(b) *To prove continued entitlement.* After a claimant establishes entitlement to an annuity, the Board may ask that annuitant to produce by a certain date information or evidence needed to decide whether he or she may continue to receive an annuity or whether the annuity should be reduced or stopped. If the information is not received by the date specified, the Board may decide that the person is no longer entitled to benefits or that his or her annuity should be stopped or reduced.

§ 219.4 Who is responsible for furnishing evidence.

(a) *Claimant or representative responsible.* When evidence is required to prove a person's eligibility for or right to continue to receive annuity or lump-sum payments, that claimant or his or her representative is responsible for obtaining and submitting the evidence to the Board.

(b) *What to do when required evidence will be delayed.* When the required evidence cannot be furnished within the specified time, the claimant or representative who was asked to furnish the evidence or information should notify the Board and explain why there will be a delay. If the delay is caused by illness, failure to receive the information from another source, or a similar situation, the claimant will be allowed a reasonable time to secure the evidence or information. If the information is not received within a reasonable time as determined by the Board, the claimant or representative who was asked to furnish the evidence or information will be notified of the effect that his or her failure to furnish the evidence or information will have on the claimant's eligibility to receive or continue to receive payments.

§ 219.5 Where and how to provide evidence.

(a) *When Board office is accessible.* A claimant or representative should give his or her evidence to an employee of the Railroad Retirement Board office where he or she files the application. An employee of the Board will tell the claimant or representative what is needed and how to get it.

(b) *When Board office is not accessible.* A claimant who lives in an area where there is no Board office or who is unable to travel to a Board office may send evidence to the Board office nearest to where the claimant lives. A claimant who lives outside the United States may take evidence to the American embassy or consulate or other Foreign Service Office nearest to where he or she lives or send it to the headquarters of the Board.

§ 219.6 Records as evidence.

(a) *General.* If a claimant or an annuitant provides an original document or record as evidence to prove eligibility or continued entitlement to payments, where possible, a Board employee will make a photocopy or transcript of these original documents or records and return the original documents to the person who furnished them. A claimant may also submit certified copies of original records as described in paragraph (c) of this section. The Board may also accept uncertified copies as described in paragraph (d) of this section.

(b) *Foreign-language documents.* If the evidence submitted is a foreign-language document, the Board may require that the record be translated. An acceptable translation includes, but is not limited to, a translation certified by a United States consular official or employee of the Department of State authorized to certify evidence, or by an employee of the Board or the Social Security Administration.

(c) *Certified copies of original records.* The Board will accept copies of original records or extracts from records if they are certified as true and exact copies of the original by—

(1) The official custodian of the record;

(2) A Veterans Administration employee, if the evidence was given to that agency to obtain veterans benefits;

(3) A Social Security Administration employee, if the evidence was given to that agency to obtain social security benefits;

(4) A United States Consular Officer, an employee of the Department of State, or an employee of the Immigration and Naturalization Service authorized to certify evidence received outside the United States; or

(5) An employee of a state agency or state welfare office authorized to certify copies of original records in the agency's or office's files.

(d) *Uncertified copies and facsimiles.* In lieu of certified paper copies of records or extracts from such official sources as listed in paragraph (c) of this section, the Board will accept facsimile copies of such records or extracts when the official custodian of such records transmits the facsimile directly to an office of the Board and the source of the transmittal is clearly identified on the facsimile.

[54 FR 31942, Aug. 3, 1989, as amended at 65 FR 19829, Apr. 13, 2000]

§ 219.7 How the Board decides what is convincing evidence.

When the Board receives evidence, a Board representative examines it to see if it is convincing evidence. If it is, no other evidence is needed. In deciding whether the evidence is convincing, the Board representative decides whether—

(a) The information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) The information contained in the evidence was given under oath, or in the presence of witnesses, or with the knowledge that there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly after;

(e) The evidence has been altered or has any erasures on it; and

(f) The information contained in the evidence agrees with other available evidence, including existing Board records.

§ 219.8 Preferred evidence and other evidence.

(a) *Preferred evidence.* When a claimant submits the type of evidence shown as preferred in subparts B and C of this part, the Board will generally find it is convincing evidence. This means that unless there is information in the Board's records that raises a doubt about the evidence, other evidence to prove the same fact will not be needed.

(b) *Other evidence.* If preferred evidence is not available, the Board will consider any other evidence a claimant furnishes. If the other evidence consists of several different records or documents which all show the same information, the Board may determine that it is convincing evidence even though it is not preferred evidence. If the other evidence is not convincing by itself, the claimant will be asked to submit additional evidence. If the additional evidence shows the same information all the evidence considered together may be convincing evidence.

(c) *Board decision.* When the Board has convincing evidence of the facts that must be proven, or when it is clear that the evidence provided does not prove the necessary facts, the Board will make a formal decision about the applicant's rights to benefits.

§ 219.9 Evidence, information, and records filed with the Board.

The Railroad Retirement Act provides criminal penalties for any persons who misrepresent the facts or make false statements to obtain payments for themselves or someone else. All evidence and documents given to the Board are kept confidential and are not disclosed to anyone but the person who submitted them, except under the rules described in part 200 of this chapter.

Subpart B—Evidence of Age and Death

§ 219.20 When evidence of age is required.

(a) Evidence of age is required when an employee applies for an annuity under the Railroad Retirement Act or for Medicare coverage under title XVIII of the Social Security Act.

(b) Evidence of age is also required from a person who applies for a spouse's or divorced spouse's, widow's, widower's, surviving divorced spouse's, parent's, or child's annuity under the Railroad Retirement Act, or for Medicare coverage under title XVIII of the Social Security Act.

§ 219.21 Types of evidence to prove age.

(a) *Preferred evidence.* The best type of evidence to prove a claimant's age is—

(1) A birth certificate recorded before age 5;

(2) A church record of birth or baptism recorded before age 5; or

(3) Notification of registration of birth made before age 5.

(b) *Other evidence of age.* If an individual cannot obtain preferred evidence of age, he or she will be asked to submit other convincing evidence to prove age. The other evidence may be one or more of the following records, with the records of highest value listed first:

(1) Hospital birth record or certificate.

(2) Physician's or midwife's birth record.

(3) Bible or other family record.

(4) Naturalization record.

(5) Military record.

(6) Immigration record.

(7) Passport.

(8) Selective service registration record.

(9) Census record.

(10) School record.

(11) Vaccination record.

(12) Insurance record.

(13) Labor union or fraternal record.

(14) Employer's record.

(15) Marriage record.

(16) A statement signed by the individual giving the reason why he or she cannot obtain other convincing evidence of age and the sworn statements of two other persons who have personal knowledge of the age that the individual is trying to prove.

(Approved by the Office of Management and Budget under control number 3220–0106)

§ 219.22 When evidence of death is required.

(a) *When evidence of the employee's death is required.* Evidence to prove the employee's death is always required for payment of any type of survivor annuity or lump-sum payment based on the deceased employee's record. See parts 216 and 234 for types of survivor payments.

(b) *When evidence to prove death of other persons is required.* Evidence to prove the death of persons other than the empoyee is required when—

(1) A claimant, who is eligible for survivor benefits, dies after the employee;

(2) A residual lump sum (see part 234 of this chapter) is payable and a person whom the employee named to receive all or part of this payment dies before the employee, or such person dies after the employee but before receiving his or her share of the benefit; or

(3) There is reasonable doubt of the death of—

(i) Any person who, if alive, has priority over the applicant;

(ii) Any spouse whose death is alleged to have ended a previous marriage, if a later marriage in question cannot be presumed valid under state law; or

(iii) Any person the termination of whose entitlement would increase payments to other entitled persons.

§ 219.23 Evidence to prove death.

(a) *Preferred evidence of death.* The best evidence of a person's death is—

(1) A certified copy of or extract from the public record of death, or verdict of the coroner's jury of the state or community where death occurred; or a certificate or statement of death issued by a local registrar or public health official;

(2) A signed statement of the funeral director, attending physician, or official of an institution where death occurred;

(3) A certified copy of, or extract from, an official report or finding of

death made by an agency or department of the United States or of a state; or

(4) If death occurred outside the United States, an official report of death by a United States Consul or other authorized employee of the State Department, or a certified copy of the public record of death in a foreign country.

(b) *Other evidence of death.* If the preferred evidence of death cannot be obtained, the individual who must furnish evidence of death will be asked to explain the reason therefor and to submit other convincing evidence, such as sworn statements of at least two persons who have personal knowledge of the death. These persons must be able to swear to the date, time, place, and cause of death.

(Approved by the Office of Management and Budget under control number 3220–0077)

§ 219.24 Evidence of presumed death.

When a person cannot be proven dead but evidence of death is needed, the Board may presume he or she died at a certain time if the Board receives the following evidence:

(a) A certified copy of, or extract from, an official report or finding by an agency or department of the United States that a missing person is presumed to be dead as stated in Federal law (5 U.S.C. 5565). Unless other evidence is submitted showing an actual date of death, the Board will use the date on which the person was reported missing as the date of death.

(b) Signed statements by those in a position to know that facts and other records which show that the person has been absent from his or her residence for no apparent reason and has not been heard from for at least 7 years. If there is no evidence available that that person continued in life after the date of disappearance, the Board will use as the date of death the date the person disappeared.

(c) When a person has been missing for less than 7 years but may be presumed dead due to drowning or common disaster (fire, accident, etc.), signed statements from the applicant and individuals who know the circumstances surrounding the occurrence leading to the person's disappearance. The best evidence is statements from individuals who witnessed the occurrence or saw the missing person at the scene of the occurrence shortly before it happened.

Subpart C—Evidence of Relationship

§ 219.30 When evidence of marriage is required.

(a) *When an application is filed for benefits.* Documentary evidence of marriage is required when an individual files for a monthly annuity, lump-sum death payment, residual lump sum, or Medicare coverage, as the wife, husband, widow, widower, divorced spouse or surviving divorced spouse, or stepparent of the employee. A claimant may also be required to submit evidence of another person's marriage when that person's marriage is necessary to determine the applicant's entitlement to benefits under the Railroad Retirement Act.

(b) *State law.* In deciding whether the marriage to the employee is valid or not, in a case where the employee is living, the Board will follow the law of the state where the employee had a permanent home when the applicant filed an application; in a case where the employee is dead, the Board will follow the law of the state where the employee had a permanent home when he or she died.

(c) *Types of evidence.* What evidence will be required depends on whether the employee's marriage was a ceremonial marriage, a common-law marriage, or a marriage that can be deemed to be valid.

§ 219.31 Evidence of a valid ceremonial marriage.

(a) *Preferred evidence.* Preferred evidence of a ceremonial marriage is—

(1) A copy of the public record of the marriage, certified by the custodian of the record or by a Board employee;

(2) A copy of a church record of the marriage certified by the custodian of the record or by a Board employee; or

(3) The original certificate of marriage.

(b) *Other evidence of a ceremonial marriage.* If preferred evidence of a ceremonial marriage cannot be obtained, the

applicant must state the reason therefor in writing and submit either—

(1) A sworn statement of the clergyman or official who performed the marriage ceremony; or

(2) Other convincing evidence, such as the sworn statements of at least two persons who have direct knowledge of the marriage, preferably eyewitnesses to the marriage ceremony.

(Approved by the Office of Management and Budget under control number 3220–0140)

§ 219.32 Evidence of a common-law marriage.

(a) *Preferred evidence.* Evidence of a common-law marriage must give the reasons why the informant believes that a marriage exists. If the information described in this paragraph is not furnished on a form provided by the Board, it must be submitted in the form of a sworn statement. Preferred evidence of a common-law marriage is one of the following:

(1) If both the husband and wife are alive, each shall sign a statement and get signed statements from one blood relative of each. The statement of another individual may be submitted for each statement the husband or wife is unable to get from a relative. Each signed statement should show—

(i) That the husband and wife believed they were married;

(ii) The basis for this belief; and

(iii) That the husband and wife have presented themselves to the public as husband and wife.

(2) If either the husband or wife is dead, the surviving spouse shall furnish a signed statement and signed statements from two blood relatives of the dead spouse. The surviving spouse's statement should show that he or she and the dead spouse believed themselves to be married, the basis for this belief, and that they presented themselves to the public as husband and wife. The statements from relatives of the dead spouse should support the surviving spouse's statement.

(3) If both husband and wife are dead, the applicant shall get a signed statement from one blood relative of each dead spouse. Each statement should show that the husband and wife believed themselves to be married, the basis for this belief, and that they presented themselves to the public as husband and wife.

(4) Statements by relatives and other individuals described in paragraphs (a)(1), (2) and (3) of this section are not required when—

(i) The husband and wife entered into a ceremonial marriage which was void because of a legal impediment to the marriage;

(ii) After the impediment was removed, the husband and wife continued to live together as man and wife until the employee filed an application or one of them died; and

(iii) A valid common-law marriage was established, under the law of the State in which they lived, by their continuing to live together as man and wife.

(b) *Other evidence of common-law marriage.* When preferred evidence of a common-law marriage cannot be obtained, the claimant will be asked to explain the reason therefor and to furnish other convincing evidence of the marriage.

(Approved by the Office of Management and Budget under control number 3220–0021)

§ 219.33 Evidence of a deemed valid marriage.

(a) *Preferred evidence.* Preferred evidence of a deemed valid marriage is—

(1) Evidence of a ceremonial marriage as described in § 219.31;

(2) If both the employee and spouse are alive, the spouse's signed statement that he or she went through the ceremony in good faith and his or her reasons for believing the marriage was valid; or if the employee is dead, the widow or widower's signed statement to that effect;

(3) If required to remove a reasonable doubt, the signed statements of other persons who have information about what the parties knew about any previous marriage or other facts showing whether the parties went through the marriage ceremony in good faith; and

(4) Evidence that the parties were living in the same household when the employee applied for payments; or, if the employee is dead, when he or she died. See § 219.51 for the evidence required to demonstrate living in the same household.

(b) *Other evidence of a deemed valid marriage.* If preferred evidence of a deemed valid marriage cannot be obtained, the claimant must explain the reason therefor and submit other convincing evidence of the marriage.

(Approved by the Office of Management and Budget under control number 3220–0140)

§ 219.34 When evidence that a marriage has ended is required.

Evidence of how a previous marriage ended may be required to determine whether a later marriage is valid. If a widow or widower remarried after the employee's death and that marriage was annulled, evidence of the annulment is required. If the claimant is a divorced spouse or surviving divorced spouse, evidence to prove a final or absolute divorce from the employee may be required.

§ 219.35 Evidence that a marriage has ended.

(a) *Preferred evidence.* Preferred evidence that a marriage has ended is—

(1) A certified copy of the decree of divorce or annulment; or

(2) Evidence of the death (See § 219.23) of a party to the marriage.

(b) *Other evidence that a marriage has ended.* If preferred evidence that the marriage has ended cannot be obtained, the claimant must explain the reason therefor and submit other convincing evidence that the marriage has ended.

(Approved by the Office of Management and Budget under control numbers 3220–0021 and 3220–0140)

§ 219.36 When evidence of a parent or child relationship is required.

(a) *When parent or child applies.* A person who applies for a parent's or child's annuity or for Medicare coverage is required to submit evidence of his or her relationship to the deceased employee.

(b) *When individual with child in care applies.* An individual who applies for an annuity because he or she has a child of the employee in care is required to submit evidence of the child's relationship to the employee.

(c) *Evidence required depends on relationship.* The evidence the Board will require depends on whether the person is the employee's natural child, adopted child, stepchild, grandchild, or stepgrandchild; or whether the person is the employee's natural parent or adopting parent.

§ 219.37 Evidence of natural parent or child relationship.

(a) *Preferred evidence.* If the claimant is the natural parent of the employee, preferred evidence of the ralationship is a copy of the employee's public or religious birth record. If the claimant is the natural child of the employee, preferred evidence of the relationship is a copy of the child's public or religious birth record.

(b) *Other evidence of parent or child relationship.* (1) When preferred evidence of a parent or child relationship cannot be obtained, the Board may ask the applicant for evidence of the employee's marriage or of the marriage of the employee's parents if that is needed to remove any reasonable doubt of the relationship.

(2) To show that a person is the child of the employee, the person may be asked for evidence that he or she would be able to inherit the employee's personal property under the law of the state where the employee died or had a permanent home.

(3) In some instances the Board may ask for a signed statement from the employee that a person is his or her natural child, or for a copy of a court order showing that the person has been declared to be the child of the employee, or for a copy of a court order requiring the employee to contribute to the person's support because the person is his or her child, or for any other supporting evidence which may be required in order to establish that the person is the child of the employee.

§ 219.38 Evidence of stepparent or stepchild relationship.

If the claimant is a stepparent or stepchild of the employee, the Board will ask for the evidence described in § 219.37 or § 219.39 which shows the person's natural or adoptive relationship to the employee's husband, wife, widow, or widower. The Board will also ask for evidence of the husband's, wife's, widow's or widower's marriage to the employee (See §§ 219.30–219.33).

§ 219.39 Evidence of relationship by legal adoption—parent or child.

(a) *Preferred evidence.* Preferred evidence of legal adoption is—

(1) A copy of the decree or order of adoption, certified by the custodian of the record;

(2) A photocopy of the decree or order of adoption; or

(3) If the widow or widower adopted the child after the employee's death, the evidence described in paragraph (a)(1) or (2) of this section; the widow's or widower's statement as to whether the child was living in the same household with the employee when the employee died (see §§ 219.50 and 219.51); what support, if any, the child was getting from another person or organization; and if the widow or widower had a deemed valid marriage with the employee, evidence of that marriage (see § 219.33).

(b) *Other evidence of legal adoption.* In some states the record of adoption proceedings is sealed and cannot be obtained without a court order. In this event, the Board will accept as proof of adoption an official notice received by the adopting parents at the time of adoption that the adoption has been completed or a birth certificate issued as a result of the adoption proceeding.

§ 219.40 Evidence of relationship by equitable adoption—child.

(a) *Preferred evidence.* If the claimant is a person who claims to be the equitably adopted child of the employee (or of the employee's wife, widow, widower, or husband), as defined in part 222 of this chapter, the Board will ask for evidence of the agreement to adopt if it is in writing. The Board will also ask for written statements from the child's natural parents as well as adopting parents concerning the child's relationship to the adopting parents.

(b) *Other evidence.* If the agreement to adopt was not in writing, the Board will require other convincing evidence about the child's relationship to the adopting parents.

(Approved by the Office of Management and Budget under control number 3220–0040)

§ 219.41 Evidence of relationship of grandchild or stepgrandchild.

If the child is the grandchild or stepgrandchild of the employee, the Board will require the kind of evidence described in §§ 219.36–219.38 that shows that child's relationship to his or her parents and his or her parents' relationship to the employee.

§ 219.42 When evidence of child's dependency is required.

Evidence of a child's dependency on the employee is required when—

(a) The employee is receiving an annuity that can be increased under the social security overall minimum (see part 229 of this chapter) by including a child, grandchild or a spouse who has a child in his or her care;

(b) A wife under age 65 applies for a full spouse annuity because she has a child or a grandchild of the employee in her care; or

(c) A child or someone in behalf of a child applies for a child's annuity based on the deceased employee's record.

§ 219.43 Evidence of child's dependency.

(a) *When the dependency requirement must be met.* Usually the dependency requirement must be met at one of the times shown in part 222 of this chapter.

(b) *Natural or adopted.* If the child is the employee's natural or adopted child, the Board may ask for the following evidence:

(1) A signed statement by someone who knows the facts that confirms that the child is the natural or adopted child.

(2) If the child was adopted by someone else while the employee was alive but the adoption was annulled, the Board may require a certified copy of the annulment decree or other convincing evidence of the annulment.

(3) A signed statement by someone having personal knowledge of the circumstances showing when and where the child lived with the employee and when and why they may have lived apart; and showing what contributions the employee made to the child's support and how the contributions were made.

(c) *Stepchild.* If the child is the employee's stepchild, the Board may ask for the following evidence;

(1) A signed statement by someone having personal knowledge of the circumstances showing when and where the child lived with the employee and when and why they may have lived apart.

(2) A signed statement by someone having personal knowledge of the circumstances showing what contributions the employee made to the child's support, the child's ordinary living costs and the income and support the child received from any other source during the relevant time as required by § 222.55 of this chapter.

(d) *Grandchild or stepgrandchild.* If the child is the employee's grandchild or stepgrandchild, the Board will require the evidence described in paragraph (c) of this section. The Board will also require evidence of the employee's death or disability.

(Approved by the Office of Management and Budget under control number 3220–0099)

§ 219.44 Evidence of relationship of a person other than a parent or child.

(a) *Claimants other than child or parent.* When any person other than a child or parent applies for benefits due because of the employee's death or because of the death of a beneficiary, the Board may ask the claimant for evidence of relationship.

(b) *Evidence required.* The type of evidence required is dependent upon the amount payable and the claimant's relationship to the deceased employee or beneficiary.

(c) *More than one eligible and claimants agree on relationship.* If there is more than one person eligible for benefits, and all eligible persons agree on the relationship of each other eligible person, only one of the persons will be asked to furnish proof of relationship. For example, if brothers and sisters of a deceased employee file applications for the residual lump sum or annuity payments due but unpaid at death, only one of them need file proof of relationship if their applications indicate that there is no dispute as to who are the brothers and sisters of the employee.

Subpart D—Other Evidence Requirements

§ 219.50 When evidence of "living with" is required.

Evidence of ''living with'' (see part 222 of this chapter on Family Relationships) is required when—

(a) The employee's spouse applies for a spouse's annuity as a deemed spouse; or

(b) The employee's legal widow or widower applies for a lump-sum death payment, annuity payments due the employee but unpaid at death, or a residual lump-sum death payment on the basis of that relationship, or the employee's deemed widow or widower applies for a widow's or widower's annuity.

§ 219.51 Evidence to prove "living with".

The following evidence may be required:

(a) If the employee is alive, both the employee and his or her spouse must sign a statement that they are living together in the same household when the spouse applies for a spouse's annuity as a deemed spouse.

(b) If the employee is dead, the widow or widower must sign a statement showing whether he or she was living together in the same household with the employee when the employee died.

(c) If the employee and spouse, widow or widower were temporarily living apart, a signed statement is required explaining where each was living, how long the separation lasted, and the reason for separation. If more evidence is required to remove any reasonable doubt about the temporary nature of the separation, the Board may ask for sworn statements of other persons having personal knowledge of the facts or for other convincing evidence.

(d) If the employee and spouse, widow, or widower were not living in the same household, the Board may ask for evidence that the employee was contributing to or under court order to contribute to the support of his or her spouse, widow, or widower. Evidence of contributions or a certified copy of the order for support may be requested. The court order for support must be in effect on the day the spouse applies for

a spouse's annuity or, if the employee is dead, the day of the employee's death. This type of evidence does not apply for purposes of establishing a deemed valid marriage. (See part 222 of this chapter.) A deemed spouse, widow, or widower must furnish evidence as described in paragraphs (a) and (b) of this section.

(Approved by the Office of Management and Budget under control number 3220–0030)

§ 219.52 When evidence of having a child in care is required.

A person who applies for a spouse's, widow's or widower's, or surviving divorced spouse's annuity on the basis of caring for a child, or for an increase under the social security overall minimum guaranty provision based on caring for a child, is required to furnish evidence that he or she has in care an eligible child of the employee as described in part 222 of this chapter. What evidence the Board will require depends upon whether the child is living with the applicant or with someone else.

§ 219.53 Evidence of having a child in care.

(a) *Preferred evidence of having a child in care.* Preferred evidence of having a child in care is—

(1) If the child is living with the applicant, the claimant's signed statement showing that the child is living with him or her.

(2) If the child is living with someone else—

(i) The claimant's signed statement showing with whom the child is living and why. The claimant must also show when the child last lived with him or her, how long the separation will last, and what care and contributions he or she provides for the child; and

(ii) The signed statement of the person with whom the child is living showing what care the claimant provides and the sources and amounts of support received by the child. If the child is in an institution, an official thereof should sign the statement. A copy of any court order or written agreement showing who has custody of the child should be provided to the Board.

(b) *Other evidence.* If the preferred evidence described in paragraph (a) of this section cannot be obtained, the Board will require other convincing evidence that the applicant has the child in care.

(Approved by the Office of Management and Budget under control numbers 3220–0030 and 3220–0042)

§ 219.54 When evidence of school attendance is required.

If a child age 18 applies for payments as a student, the Board will require evidence that the child is attending elementary or secondary school. After the child has started his or her school attendance, the Board may also ask for evidence that he or she is continuing to attend school full time. To be acceptable to the Board, the child must submit the evidence of school attendance within 90 days of the date the evidence is requested by the Board.

§ 219.55 Evidence of school attendance for child age 18.

The child will be asked to submit (on a form furnished by the Board or other form acceptable to the Board) the following evidence:

(a) A signed statement that he or she is attending school full-time and is not being paid by an employer to attend school; and

(b) A statement from an official of the school verifying that the child is attending school full-time. The Board may also accept as evidence a letter of acceptance from the school, receipted bill, or other evidence showing that the child has enrolled or been accepted at that school or is continuing in full-time attendance.

(Approved by the Office of Management and Budget under control numbers 3220–0030, 3220–0083, and 3220–0123)

§ 219.56 When evidence of a parent's support is required.

If a person applies for a parent's annuity, the Board will require evidence to show that the parent received at least one-half of his or her support from the employee in the one-year period before—

(a) The employee died; or

(b) The beginning of a period of disability if the employee had a period of disability which did not end before his or her death.

§ 219.57 Evidence of a parent's support.

(a) The Board will require the parent's signed statement showing his or her income, any other sources of support, the amount from each source and his or her expenses during the one-year period.

(b) The Board may also ask the parent for signed statements from other people who know the facts about his or her sources of support.

(c) If the statements described in paragraphs (a) and (b) of this section cannot be obtained, the Board will require other convincing evidence that the parent is receiving one-half of his or her support from the employee.

(Approved by the Office of Management and Budget under control number 3220–0099)

§ 219.58 When evidence regarding payment of burial expenses is required.

If a person applies for the lump-sum death payment because he or she is responsible for paying the funeral home or burial expenses of the employee or because he or she has paid some or all of these expenses, the Board will require evidence of such payment.

§ 219.59 Evidence of responsibility for or payment of burial expenses.

The Board will ask for the following evidence:

(a) The claimant's signed statement showing—

(1) That he or she accepted responsibility for the funeral home expenses or paid some or all of these expenses or other burial expenses; or the name and address of the person who accepted responsibility for or paid these expenses;

(2) Total funeral home expenses and, if necessary, the total of other burial expenses; and if someone else paid part of the expenses, that person's name, address, and the amount he or she paid;

(3) The amount of cash or property the applicant expects to receive as repayment for any burial expenses he or she paid; and whether anyone has applied for any burial allowance from the Veterans Administration or other governmental agency for these expenses; and

(4) If the claimant is an owner or official of a funeral home, a signed statement from anyone, other than employee of the home, who helped make the burial arrangements showing whether he or she accepted responsibility for paying the burial expenses.

(b) Unless the claimant is an owner or official of a funeral home, a signed statement from the owner or official of the funeral home which handled the deceased employee's funeral and, if necessary, from those who supplied other burial goods or services which shows—

(1) The name and address of everyone who accepted responsibility for or paid any part of the burial expenses; and

(2) Information which the owner or official of the funeral home and, if necessary, any other supplier has about the expenses and payments described in paragraphs (a)(2) and (a)(3) of this section.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 219.60 When evidence of the employee's permanent home is required.

The Board may ask for evidence to prove where the employee had a permanent home at the time of filing an application or, if earlier, at the time the employee died if—

(a) The claimant is applying for payments as the employee's wife, husband, widow, widower, parent, or child; and

(b) The claimant's relationship to the employee depends upon the laws of the state where the employee had his or her permanent home when his or her wife or husband applied for an annuity or when the employee died.

§ 219.61 Evidence of where the employee had a permanent home.

The Board will ask for the following evidence to establish the employee's permanent home:

(a) The claimant's signed statement showing what the employee considered to be his or her permanent home.

(b) If the statement in paragraph (a) of this section or other evidence raises a reasonable doubt in establishing the employee's permanent home, evidence of where the employee paid personal property taxes, real estate taxes, or income taxes; or evidence where the employee voted; or other convincing evidence.

§ 219.62 When evidence of "good cause" is required.

The principle of ''good cause'', as defined in part 217 of this chapter, is applied by the Board in determining whether to allow an application which is submitted more than two years after the employee's death as acceptable for the lump-sum death payment or for an annuity unpaid at death, or to accept the proof of support required for entitlement to a parent's annuity if such proof is filed more than two years after the employee's death.

§ 219.63 What evidence is required to establish "good cause".

The Board will ask for the following evidence of ''good cause'':

(a) The claimant's signed statement explaining why he or she did not file the application for lump-sum death payment or annuity unpaid at death or the parent's proof of support within the specified two-year period.

(b) If the statement in paragraph (a) of this section or other evidence raises a reasonable doubt as to whether there was good cause, other convincing evidence to establish ''good cause''.

§ 219.64 When evidence may be required for other reasons.

(a) The Board will require evidence of the appointment of a legal representative when—

(1) The employee's estate is entitled to a lump-sum death payment, annuity unpaid at death, or residual lump sum, and an executor or administrator has been appointed for the estate; or

(2) A minor child or incompetent is entitled to an annuity or lump-sum payment and a guardian, trustee, committee, or conservator has been appointed to act in his or her behalf.

(b) The Board will require evidence of an annuitant's earnings when the information that he or she furnished the Board does not agree with the earnings data furnished by the Social Security Administration or secured from other sources, and the annuitant maintains that the earnings data from the Social Security Administration or from other sources is not correct.

(c) The Board will require evidence to establish the amounts paid as a public service pension, public disability benefit, or worker's compensation to an employee, spouse, widow, or widower when the pension, public disability benefit, or worker's compensation affects the amount of his or her annuity.

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0136, and 3220–0154)

(d) The Board will require evidence to reconcile discrepancies between the information furnished by the claimant and information already in the records of the Board, the Social Security Administration, or other public agencies. Such discrepancies may be differences in name, date or place of birth, periods of employment, or other identifying data.

§ 219.65 Other types of evidence that may be required.

(a) The Board may ask for a statement from an employer listing the annuitant's earnings by months and explaining any payments made to the annuitant when he or she was not working.

(b) The Board may ask for copies of award notices from a public agency showing the amounts of periodic payments and the period covered by each payment.

(c) The Board may ask for a statement from the applicant explaining discrepancies and may ask for sworn statements from persons who have personal knowledge of the facts or for any other convincing evidence.

(d) The Board may ask for proof of the court appointment of a legal representative, such as:

(1) Certified copy of letters of appointment;

(2) ''Short'' certificate;

(3) Certified copy of order of appointment; or

(4) Any official document issued by the clerk or other proper official of the appointing court.

PART 220—DETERMINING DISABILITY

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APPENDIX 1 TO PART 220—LISTING OF IMPAIRMENTS
APPENDIX 2 TO PART 220—MEDICAL-VOCATIONAL GUIDELINES
APPENDIX 3 TO PART 220—RAILROAD RETIREMENT BOARD OCCUPATIONAL DISABILITY STANDARDS

AUTHORITY: 45 U.S.C. 231a; 45 U.S.C. 231f.

SOURCE: 56 FR 12980, Mar. 28, 1991, unless otherwise noted.

Subpart A—General

§ 220.1 Introduction of part.

(a) This part explains how disability determinations are made by the Railroad Retirement Board. In some determinations of disability entitlement, as described below, the Board makes the decision of disability under the Railroad Retirement Act based on the regulations set out in this part. However, in certain other determinations of disability entitlement (as also described below) the Board has the authority to decide whether the claimant is disabled as that term is defined in the Social Security Act and the regulations of the Social Security Administration.

(b) In order for a claimant to become entitled to a railroad retirement annuity based on disability for his or her regular railroad occupation, or to become entitled to a railroad retirement annuity based on disability for any regular employment as an employee, widow(er), or child, he or she must be disabled as those terms are defined in the Railroad Retirement Act. In order

for a claimant to become entitled to a period of disability, to early Medicare coverage based on disability, to benefits under the social security overall minimum, or to a disability annuity as a surviving divorced spouse or remarried widow(er), the claimant must be found disabled as that term is defined in the Social Security Act.

§ 220.2 The basis for the Board's disability decision.

(a) The Board makes disability decisions for claims of disability under the Railroad Retirement Act. These decisions are based either on the rules contained in the Board's regulations in this part or the rules contained in the regulations of the Social Security Administration, whichever is controlling.

(b) A disability decision is made only if the claimant meets other basic eligibility requirements for the specific disability benefit for which he or she is applying. For example, a claimant for an occupational disability annuity must first meet the eligibility requirements for that annuity, as explained in part 216 of this chapter, in order for the Board to make a disability decision.

§ 220.3 Determinations by other organizations and agencies.

Determinations of the Social Security Administration or any other governmental or non-governmental agency about whether or not a claimant is disabled under the laws, regulations or standards administered by that agency shall be considered by the Board but are not binding on the Board.

Subpart B—General Definitions of Terms Used in This Part

§ 220.5 Definitions as used in this part.

Act means the Railroad Retirement Act of 1974.

Application refers only to a form described in part 217 of this chapter.

Board means the Railroad Retirement Board.

Claimant means the person for whom an application for an annuity, period of disability or Medicare coverage is filed.

Eligible means that a person would meet all the requirements for payment of an annuity but has not yet applied.

Employee is defined in part 203 of this title.

Entitled means that a person has applied and has proven his or her right to have the annuity, period of disability, or Medicare coverage begin.

Medical source refers to both a treating source and a source of record.

Review physician means a medical doctor either employed by or under contract to the Board who upon request reviews medical evidence and provides medical advice.

Social security overall minimum refers to the provision of the Railroad Retirement Act which guarantees that the total monthly annuities payable to an employee and his or her family will not be less than the total monthly amount which would be payable under the Social Security Act if the employee's railroad service were credited as employment under the Social Security Act.

Source of record means a hospital, clinic or other source that has provided a claimant with medical treatment or evaluation, as well as a physician or psychologist who has treated or evaluated a claimant but does not have an ongoing relationship with him or her.

Treating source means the claimant's own physician or psychologist who has provided the claimant with medical treatment or evaluation and who has an ongoing treatment relationship with him or her.

Subpart C—Disability Under the Railroad Retirement Act for Work in an Employee's Regular Railroad Occupation

§ 220.10 Disability for work in an employee's regular railroad occupation.

(a) In order to receive an occupational disability annuity an eligible employee must be found by the Board to be disabled for work in his or her regular railroad occupation because of a permanent physical or mental impairment. In this subpart the Board describes in general terms how it evaluates a claim for an occupational disability annuity. In accordance with section 2(a)(2) of the Railroad Retirement Act this subpart was developed with the cooperation of employers and

employees. This subpart is supplemented by an Occupational Disability Claims Manual (Manual)[1] which was also developed with the cooperation of employers and employees.

(b) In accordance with section 2(a)(2) of the Railroad Retirement Act, the Board shall select two physicians, one from recommendations made by representatives of employers and one from recommendations made by representatives of employees. These individuals shall comprise the Occupational Disability Advisory Committee (Committee). This Committee shall periodically review, as necessary, this subpart and the Manual and make recommendations to the Board with respect to amendments to this subpart or to the Manual. The Board shall confer with the Committee before it amends either this subpart or the Manual.

[63 FR 7541, Feb. 13, 1998]

§ 220.11 Definitions as used in this subpart.

Functional capacity test means one of a number of tests which provide objective measures of a claimant's maximal work ability and includes functional capacity evaluations which provide a systematic comprehensive assessment of a claimant's overall strength, mobility, endurance and capacity to perform physically demanding tasks, such as standing, walking, lifting, crouching, stooping or bending, climbing or kneeling.

Independent Case Evaluation (ICE) means the process for evaluating claims not covered by appendix 3 of this part.

Permanent physical or mental impairment means a physical or mental impairment or combination of impairments that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.

Regular railroad occupation means an employee's railroad occupation in which he or she has engaged in service for hire in more calendar months than the calendar months in which he or she has been engaged in service for hire in any other occupation during the last preceding five calendar years, whether or not consecutive; or has engaged in service for hire in not less than one-half of all of the months in which he or she has been engaged in service for hire during the last preceding 15 consecutive calendar years. If an employee last worked as an officer or employee of a railway labor organization and if continuance in such employment is no longer available to him or her, the ''regular occupation'' shall be the position to which the employee holds seniority rights or the position which he or she left to work for a railway labor organization.

Residual functional capacity has the same meaning as found in § 220.120.

[63 FR 7541, Feb. 13, 1998]

§ 220.12 Evidence considered.

The regulations explaining the employee's responsibility to provide evidence of disability, the kind of evidence, what medical evidence consists of, and the consequences of refusing or failing to provide evidence or to have a medical examination are found in § 220.45 through § 220.48. The regulations explaining when the employee may be requested to report for a consultative examination are found in § 220.50 and § 220.51. The regulations explaining how the Board evaluates conclusions by physicians concerning the employee's disability, how the Board evaluates the employee's symptoms, what medical findings consist of, and the need to follow prescribed treatment are found in § 220.112 through § 220.115.

[56 FR 12980, Mar. 28, 1991. Redesignated at 63 FR 7541, Feb. 13, 1998]

§ 220.13 Establishment of permanent disability for work in regular railroad occupation.

The Board will presume that a claimant who is not allowed to continue working for medical reasons by his employer has been found, under standards contained in this subpart, disabled unless the Board finds that no person could reasonably conclude on the basis of evidence presented that the claimant can no longer perform his or her regular railroad occupation for medical reasons. (See § 220.21 if the claimant is

[1] The Manual may be obtained from the Board's headquarters at 844 North Rush Street, Chicago, IL 60611.

not currently disabled, but was previously occupationally disabled for a specified period of time in the past). The Board uses the following evaluation process in determining disability for work in the regular occupation:

(a) The Board evaluates the employee's medically documented physical and mental impairment(s) to determine if the employee has an impairment which is listed in the Listing of Impairments in appendix 1 of this part. That Listing describes impairments which are considered severe enough to prevent a person from doing any substantial gainful activity. If the Board finds that an employee has an impairment which is listed or is equal to one which is listed, it will find the employee disabled for work in his or her regular occupation without considering the duties of his or her regular occupation.

(b) If the Board finds that the claimant does not have an impairment described in paragraph (a) of this section, it will—

(1) Determine the employee's regular railroad occupation, as defined in § 220.11, based upon the employee's own description of his or her job;

(2) Evaluate whether the claimant is disabled as follows:

(i) The Board first determines whether the employee's regular railroad occupation is an occupation covered under appendix 3 of this part. Second, the Board will determine whether the employee's claimed impairment(s) is covered under appendix 3 of this part. If claimant's regular railroad occupation or impairment(s) is not covered under appendix 3 of this part, then the Board will determine if the employee is disabled under ICE as set forth in paragraph (b)(2)(iv) of this section.

(ii)(A) If the Board determines that, in accordance with paragraph (b)(2)(i) of this section, appendix 3 of this part applies, then the Board will confirm the existence of the employee's impairment(s) using—

(*1*) The ''highly recommended'' and ''recommended'' tests set forth in appendix 3 of this part that relate to the body part affected by the claimant's impairment(s); or

(*2*) By using valid diagnostic tests accepted by the medical community as described in § 220.27.

(B) If the employee's impairment(s) cannot be confirmed because there are significant differences in objective tests such as imaging study, electrocardiograms or other test results, and these differences cannot be readily resolved, the Board will determine if the employee is disabled under ICE as set forth in paragraph (b)(2)(iv) of this section. However, if the employee's impairment(s) cannot be confirmed, and there are no significant differences in objective medical tests which cannot be readily resolved, then the employee will be found not disabled.

(iii) Once the impairment(s) is confirmed, as provided for in paragraph (b)(2)(ii) of this section, the Board will apply appendix 3 of this part. If appendix 3 of this part dictates a ''D'' (disabled) finding, the Board will find the claimant disabled.

(iv) If the Board does not find the employee disabled using the standards in appendix 3 of this part, then the Board will determine if the employee is disabled using ICE. To evaluate a claim under ICE the Board will use the following steps:

(A) *Step 1.* The Board will determine if the medical evidence is complete. Under this step the Board may request the claimant to take additional medical tests such as a functional capacity test or other consultative examinations;

(B) *Step 2.* If the employee's impairment(s) has not been confirmed, as provided for in paragraph (b)(2)(ii)(A)(*2*) of this section, the Board will next confirm the employee's impairment(s), as described in paragraph (b)(2)(ii)(A)(*2*) of this section;

(C) *Step 3.* The Board will determine whether the opinions among the physicians regarding medical findings are consistent, by reviewing the employee's medical history, physical and mental examination findings, laboratory or

other test results, and other information provided by the employee or obtained by the Board. If such records reveal that there are significant differences in the medical findings, significant differences in opinions concerning the residual functional capacity evaluations among treating physicians, or significant differences between the results of functional capacity evaluations and residual functional capacity examinations, then the Board may request additional evidence from treating physicians, additional consultative examinations and/or residual functional capacity tests to resolve the inconsistencies;

(D) *Step 4.* When the Board determines that there is concordance of medical findings, then the Board will assess the quality of the evidence in accordance with § 220.112, which describes the weight to be given to the opinions of various physicians, and § 220.114, which describes how the Board evaluates symptoms such as pain. The Board will also assess the weight of evidence by utilizing § 220.14, which outlines factors to be used in determining the weight to be attributed to certain types of evidence. If, after assessment, the Board determines that there is no substantial objective evidence of an impairment, the Board will determine that the employee is not disabled;

(E) *Step 5.* Next, the Board determines the physical and mental demands of the employee's regular railroad occupation. In determining the job demands of the employee's regular railroad occupation, the Board will not only consider the employee's own description of his or her regular railroad occupation, but shall also consider the employer's description of the physical requirements and environmental factors relating to the employee's regular railroad occupation, as provided by the employer on the appropriate form set forth in appendix 3 of this part, and consult other sources such as the Dictionary of Occupational Titles and the job descriptions of occupations found in the Occupational Disability Claims Manual, as provided for in § 220.10;

(F) *Step 6.* Based upon the assessment of the evidence in paragraph (b)(2)(iv)(D) of this section, the Board shall determine the employee's residual functional capacity. The Board will then compare the job demands of the employee's regular railroad occupation, as determined in paragraph (b)(2)(iv)(E) of this section. If the demands of the employee's regular railroad occupation exceed the employee's residual functional capacity, then the Board will find the employee disabled. If the demands do not exceed the employee's residual functional capacity, then the Board will find the employee not disabled.

[56 FR 12980, Mar. 28, 1991, as amended at 63 FR 7541, Feb. 13, 1998]

§ 220.14 Weighing of evidence.

(a) *Factors which support greater weight.* Evidence will generally be given more weight if it meets one or more of the following criteria:

(1) The residual functional capacity evaluation is based upon functional objective tests with high validity and reliability;

(2) The medical evidence shows multiple impairments which have a cumulative effect on the employee's residual functional capacity;

(3) Symptoms associated with limitations are consistent with objective findings;

(4) There exists an adequate trial of therapies with good compliance, but poor outcome;

(5) There exists consistent history of conditions between treating physicians and other health care providers.

(b) *Factors which support lesser weight.* Evidence will generally be given lesser weight if it meets one or more of the following criteria:

(1) There is an inconsistency between the diagnoses of the treating physicians;

(2) There is inconsistency between reports of pain and functional impact;

(3) There is inconsistency between subjective symptoms and physical examination findings;

(4) There is evidence of poor compliance with treatment regimen, keeping appointments, or cooperating with treatment;

(5) There is evidence of exam findings which is indicative of exaggerated or potential malingering response;

(6) The evidence consists of objective findings of exams that have poor reliability or validity;

(7) The evidence consists of imaging findings which are nonspecific and largely present in the general population;

(8) The evidence consists of a residual functional capacity evaluation which is supported by limited objective data without consideration for functional capacity testing.

[63 FR 7542, Feb. 13, 1998]

§ 220.15 Effects of work on occupational disability.

(a) *Disability onset when the employee works despite impairment.* An employee who has stopped work in his or her regular occupation due to a permanent physical or mental impairment(s) may make an effort to return to work in his or her regular occupation. If the employee is subsequently forced to stop that work after a short time because of his or her impairment(s), the Board will generally consider that work as an unsuccessful work attempt. In this situation, the Board may determine that the employee became disabled for work in his or her regular occupation before the last date the employee worked in his or her regular occupation. No annuity will be payable, however, until after the last date worked.

(b) *Occupational disability annuitant work restrictions.* The restrictions which apply to an annuitant who is disabled for work in his or her regular occupation are found in §§ 220.160 through 220.164.

§ 220.16 Responsibility to notify the Board of events which affect disability.

If the annuitant is entitled to a disability annuity because he or she is disabled for work in his or her regular occupation, the annuitant should promptly tell the Board if—

(a) His or her impairment(s) improves;

(b) He or she returns to any type of work;

(c) He or she increases the amount of work; or

(d) His or her earnings increase.

§ 220.17 Recovery from disability for work in the regular occupation.

(a) *General.* Disability for work in the regular occupation will end if—

(1) There is medical improvement in the annuitant's impairment(s) to the extent that the annuitant is able to perform the duties of his or her regular occupation; or

(2) The annuitant demonstrates the ability to perform the duties of his or her regular occupation. The Board provides a trial work period before terminating a disability annuity because of the annuitant's return to work.

(b) *Definition of the trial work period.* The trial work period is a period during which the annuitant may test his or her ability to work and still be considered occupationally disabled. It begins and ends as described in paragraph (e) of this section. During this period, the annuitant may perform ''services'' (see paragraph (c) of this section) in as many as 9 months, but these months do not have to be consecutive. The Board will not consider those services as showing that the annuitant's occupational disability has ended until the annuitant has performed services in at least 9 months. However, after the trial work period has ended, the Board will consider the work the annuitant did during the trial work period in determining whether the annuitant's occupational disability has ended at any time after the trial work period.

(c) *What the Board means by services in an occupational disability case.* When used in this section, ''services'' means any activity which, even though it may not be substantial gainful activity as defined in § 220.141, is—

(1) Done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit; and

(2) The activity is a return to the same duties of the annuitant's regular occupation or the activity so closely approximates the duties of the regular occupation as to demonstrate the ability to perform those duties.

(d) *Limitations on the number of trial work periods.* The annuitant may have only one trial work period during each period in which he or she is occupationally disabled.

(e) *When the trial work period begins and ends.* (1) The trial work period begins with whichever of the following calendar months is the latest—

(i) The annuity beginning date;

(ii) The month after the end of the appropriate waiting period; or

(iii) The month the application for disability is filed.

(2) The trial work period ends with the close of whichever of the following calendar months is the earlier—

(i) The ninth month (whether or not the months have been consecutive) in which the annuitant performed services; or

(ii) The month in which new evidence, other than evidence relating to any work the annuitant did during the trial work period, shows that the annuitant is not disabled, even though the annuitant has not worked a full nine months. The Board may find that the annuitant's disability has ended at any time during the trial work period if the medical or other evidence shows that the annuitant is no longer disabled.

§ 220.18 The reentitlement period.

(a) *General.* The reentitlement period is an additional period after the nine months of trial work during which the annuitant may continue to test his or her ability to work if the annuitant has a disabling impairment.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of nine months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which the annuitant's impairment(s) no longer exists or is not medically disabling; or

(2) The last day of the 36th month following the end of the annuitant's trial work period.

(c) *When the annuitant is not entitled to a reentitlement period.* The annuitant is not entitled to a reentitlement period if—

(1) The annuitant is not entitled to a trial work period; or

(2) The annuitant's disability ended before the annuitant completed nine months of trial work in that period in which he or she was disabled.

§ 220.19 Payment of the disability annuity during the trial work period and the reentitlement period.

(a) The employee who is entitled to an occupational disability annuity will not be paid an annuity for each month in the trial work period or reentitlement period in which he or she—

(1) Works for an employer covered by the Railroad Retirement Act (see § 220.160); or

(2) Earns more than $400 (after deduction of impairment-related work expenses) in employment or self-employment (see §§ 220.161 and 220.164). See § 220.145 for the definition of impairment-related work expenses.

(b) If the employee's occupational disability annuity is stopped because of work during the trial work period or reentitlement period, and the employee discontinues that work before the end of either period, the disability annuity may be started again without a new application and a new determination of disability.

§ 220.20 Notice that an annuitant is no longer disabled.

The regulation explaining the Board's responsibilities in notifying the annuitant, and the annuitant's rights when the disability annuity is stopped is found in § 220.183.

§ 220.21 Initial evaluation of a previous occupational disability.

(a) In some cases, the Board may determine that a claimant is not currently disabled for work in his or her regular occupation but was previously disabled for a specified period of time in the past. This can occur when—

(1) The disability application was filed before the claimant's occupational disability ended, but the Board did not make the initial determination of occupational disability until after the claimant's disability ended; or

(2) The disability application was filed after the claimant's occupational disability ended but no later than the 12th month after the month the disability ended.

(b) When evaluating a claim for a previous occupational disability, the Board follows the steps in § 220.13 to determine whether an occupational disability existed, and follows the steps in

§§ 220.16 and 220.17 to determine when the occupational disability ended.

Example 1: The claimant sustained multiple fractures to his left leg in an automobile accident which occurred on June 16, 1982. For a period of 18 months following the accident the claimant underwent 2 surgical procedures which restored the functional use of his leg. After a recovery period following the last surgery, the claimant returned to his regular railroad job on February 1, 1984. The claimant, although fully recovered medically and regularly employed, filed an application on December 3, 1984 for a determination of occupational disability for the period June 16, 1982 through January 31, 1984. The Board reviewed his claim in January 1985 and determined that he was occupationally disabled for the prior period which began on June 16, 1982 and continued through January 31, 1984. A disability annuity is payable to the employee only for the period December 1, 1983 through January 31, 1984. An annuity may not begin any earlier than the 1st day of the 12th month before the month in which the application was filed. (See part 218 of this chapter for the rules on when an annuity may begin).

Example 2: The claimant is occupationally disabled using the same medical facts disclosed above, beginning June 16, 1982 (the date of the automobile accident). The claimant files an application for an occupational disability annuity, dated December 1, 1983. However, as of February 1, 1984, and before the Board makes a disability determination, the claimant returns to his regular railroad job and is no longer considered occupationally disabled. The Board reviews the claimant's application in May of 1984 and finds him occupationally disabled for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee from December 1, 1982 through January 31, 1984. (See part 218 of this chapter for the rules on when an annuity may begin).

Subpart D—Disability Under the Railroad Retirement Act for Any Regular Employment

§ 220.25 General.

The definition and discussion of disability for any regular employment are found in §§ 220.26 through 220.184.

§ 220.26 Disability for any regular employment, defined.

An employee, widow(er), or child is disabled for any regular employment if he or she is unable to do any substantial gainful activity because of a medically determinable physical or mental impairment which meets the duration requirement defined in § 220.28. In the case of a widow(er), the permanent physical or mental impairment must have prevented work in any regular employment before the end of a specific period (see § 220.30). In the case of a child, the permanent physical or mental impairment must have prevented work in any regular employment since before age 22. To meet this definition of disability, a claimant must have a severe impairment, which makes him or her unable to do any previous work or other substantial gainful activity which exists in the national economy. To determine whether a claimant is able to do any other work, the Board considers a claimant's residual functional capacity, age, education and work experience. See § 220.100 for the process by which the Board evaluates disability for any regular employment. This process applies to employees, widow(er)s, or children who apply for annuities based on disability for any regular employment. This process does not apply to surviving divorced spouses or remarried widow(er)s who apply for annuities based on disability.

§ 220.27 What is needed to show an impairment.

A physical or mental impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the claimant's statement of symptoms. (See § 220.113 for further information about what is meant by symptoms, signs, and laboratory findings.) (See also § 220.112 for the effect of a medical opinion about whether or not a claimant is disabled.)

§ 220.28 How long the impairment must last.

Unless the claimant's impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. This is known as the duration requirement.

§ 220.29 Work that is considered substantial gainful activity.

Work is considered to be substantial gainful activity if it—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done or is intended to be done for pay or profit. (See § 220.141 for a detailed explanation of what is substantial gainful activity.)

§ 220.30 Special period required for eligibility of widow(er)s.

In order to be found disabled for any regular employment, a widow(er) must have a permanent physical or mental impairment which prevented work in any regular employment since before the end of a specific period as defined in part 216 of this chapter.

Subpart E—Disability Determinations Governed by the Regulations of the Social Security Administration

§ 220.35 Introduction.

In addition to its authority to decide whether a claimant is disabled under the Railroad Retirement Act, the Board has authority in certain instances to decide whether a claimant is disabled as that term is defined in the Social Security Act. In making these decisions the Board must apply the regulations of the Social Security Administration in the same manner as does the Secretary of Health and Human Services in making disability decisions under the Social Security Act. Regulations of the Social Security Administration concerning disability are found at part 404, subpart P of this title.

§ 220.36 Period of disability.

(a) *General.* In order to receive an annuity based upon a disability, an employee must be found disabled under the Railroad Retirement Act. If an employee is found disabled under the Railroad Retirement Act, the Board will determine whether he is disabled under the Social Security Act to qualify for a period of disability as defined in that Act.

(b) *Period of disability*—(1) *Definition and effect.* A period of disability is a continuous period of time during which an employee is disabled as that term is defined in § 404.1505 of this title. A period of disability established by the Board—

(i) Preserves the disabled employee's earnings record as it is when the period begins;

(ii) Protects the insured status required for entitlement to social security overall minimum;

(iii) May cause an increase in the rate of an employee, spouse, or survivor annuity; or

(iv) May permit a disabled employee to receive Medicare benefits in addition to an annuity under the Railroad Retirement Act.

(2) *Effect on benefits.* The establishment of a period of disability for the employee will never cause a denial or reduction in benefits under the Railroad Retirement Act or Social Security Act, but it will always be used to establish Medicare entitlement before age 65.

(3) *Who may establish a period of disability.* The Railroad Retirement Board or the Social Security Administration may establish a period of disability. However, the decision of one agency is not binding upon the other agency.

(4) *When the Board may establish a period of disability.* The Board has independent authority to decide whether or not to establish a period of disability for any employee who was awarded an annuity under the Railroad Retirement Act, or who—

(i) Has applied for a disability annuity; and

(ii) Has at least 10 years of railroad service.

(5) *When an employee is entitled to a period of disability.* An employee is entitled to a period of disability if he or she meets the following requirements:

(i) The employee is disabled under the Social Security Act, as described in § 404.1505 of this title.

(ii) The employee is insured for a period of disability under § 404.130 of this title based on combined railroad and social security earnings.

(iii) The employee files an application as shown in subparagraph (b)(6) of this section.

(iv) At least 5 consecutive months elapse from the month in which the period of disability begins and before the month in which it would end.

(6) *Application for a period of disability.* (i) An application for an employee disability annuity under the Railroad Retirement Act or an employee disability benefit under the Social Security Act is also an application for a period of disability.

(ii) An employee who is receiving an age annuity or who was previously denied a period of disability must file a separate application for a period of disability.

(iii) In order to be entitled to a period of disability, an employee must apply while he or she is disabled or not later than 12 months after the month in which the period of disability ends.

(iv) An employee who is unable to apply within the 12-month period after the period of disability ends because his or her physical condition limited his or her activities to the extent that he or she could not complete and sign an application or because he or she was mentally incompetent, may apply no later than 36 months after the period of disability ends.

(v) A period of disability can also be established on the basis of an application filed within 3 months after the month a disabled employee died.

(c) *Social security overall minimum.* The social security overall minimum provision of the Railroad Retirement Act guarantees that the total monthly annuities payable to an employee and his or her family will not be less than the total monthly benefit which would be payable under the Social Security Act if the employee's railroad service were credited as employment under the Social Security Act.

(The information collection requirements contained in paragraph (b)(6) were approved by the Office of Management and Budget under control number 3220–0002)

§ 220.37 When a child's disability determination is governed by the regulations of the Social Security Administration.

(a) In order to receive an annuity based upon disability, a child of a deceased employee must be found disabled under the Railroad Retirement Act. However, in addition to this determination, the child must be found disabled under the Social Security Act in order to qualify for Medicare based upon disability.

(b) Although the child of a living employee may not receive an annuity under the Railroad Retirement Act, he or she, if found disabled under the Social Security Act, may qualify for the following:

(1) Inclusion as a disabled child in the employee's annuity rate under the social security overall minimum.

(2) Entitlement to Medicare based upon disability.

§ 220.38 When a widow(er)'s disability determination is governed by the regulations of the Social Security Administration.

In order to receive an annuity based upon disability, a widow(er) must be found disabled under the Railroad Retirement Act. However, in addition to this determination, the widow(er) must be found disabled under the Social Security Act in order to qualify for early Medicare based upon disability.

§ 220.39 Disability determination for a surviving divorced spouse or remarried widow(er).

A surviving divorced spouse or a remarried widow(er) must be found disabled under the Social Security Act in order to qualify for both an annuity under the Railroad Retirement Act and early Medicare based upon disability. Disability determinations for surviving divorced spouses and remarried widow(er)s are governed by the applicable regulations of the Social Security Administration, found at § 404.1577 of this title.

Subpart F—Evidence of Disability

§ 220.45 Providing evidence of disability.

(a) *General.* The claimant for a disability annuity is responsible for providing evidence of the claimed disability and the effect of the disability on the ability to work. The Board will assist the claimant, when necessary, in obtaining the required evidence. At its discretion, the Board will arrange for an examination by a consultant at the

expense of the Board as explained in §§ 220.50 and 220.51.

(b) *Kind of evidence.* The claimant must provide medical evidence showing that he or she has an impairment(s) and how severe it is during the time the claimant claims to be disabled. The Board will consider only impairment(s) the claimant claims to have or about which the Board receives evidence. Before deciding that the claimant is not disabled, the Board will develop a complete medical history (i.e., evidence from the records of the claimant's medical sources) covering at least the preceding 12 months, unless the claimant says that his or her disability began less than 12 months before he or she filed an application. The Board will make every reasonable effort to help the claimant in getting medical reports from his or her own medical sources when the claimant gives the Board permission to request them. Every reasonable effort means that the Board will make an initial request and, after 20 days, one follow-up request to the claimant's medical source to obtain the medical evidence necessary to make a determination before the Board evaluates medical evidence obtained from another source on a consultative basis. The medical source will have 10 days from the follow-up request to reply (unless experience indicates that a longer period is advisable in a particular case). In order to expedite processing the Board may order a consultative exam from a non-treating source while awaiting receipt of medical source evidence. If the Board ask the claimant to do so, he or she must contact the medical sources to help us get the medical reports. The Board may also ask the claimant to provide evidence about his or her—

(1) Age;

(2) Education and training;

(3) Work experience;

(4) Daily activities both before and after the date the claimant says that he or she became disabled;

(5) Efforts to work; and

(6) Any other evidence showing how the claimant's impairment(s) affects his or her ability to work. (In §§ 220.125 through 220.134, we discuss in more detail the evidence the Board needs when it considers vocational factors.)

(Approved by the Office of Management and Budget under control numbers 3220–0002, 3220–0030, 3220–0106 and 3220–0141)

§ 220.46 Medical evidence.

(a) *Acceptable sources.* The Board needs reports about the claimant's impairment(s) from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Licensed or certified psychologists;

(4) Licensed optometrists for the measurement of visual acuity and visual fields (a report from a physician may be needed to determine other aspects of eye diseases); and

(5) Persons authorized to furnish a copy or summary of the records of a medical facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Railroad Retirement Board, Social Security Administration, Department of Veterans Affairs, or State agency.

(b) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed, with response to treatment and prognosis; and

(6)(i) Statements about what the claimant can still do despite his or her impairment(s) based on the medical source's findings on the factors under paragraph (b)(1) through (5) of this section (except in disability claims for remarried widow's and surviving divorced spouses). (See § 220.112).

(ii) Statements about what the claimant can still do (based on the medical source's findings on the factors under paragraph (b)(1) through (5) of this section) should describe—

(A) The medical source's opinion about the claimant's ability, despite his or her impairment(s), to do work-

related activities such as sitting, standing, moving about, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(B) In cases of mental impairment(s), the medical source's opinion about the claimant's ability to reason or make occupational, personal, or social adjustments. (See § 220.112).

(c) *Completeness.* The medical evidence, including the clinical and laboratory findings, must be complete and detailed enough to allow the Board to make a determination about whether or not the claimant is disabled. It must allow the Board to determine—

(1) The nature and limiting effects of the claimant's impairment(s) for any period in question;

(2) The probable duration of the claimant's impairment(s); and

(3) The claimant's residual functional capacity to do work-related physical and mental activities.

(d) *Evidence from physicians.* A statement by or the opinion of the claimant's treating physician will not determine whether the claimant is disabled. However, the medical evidence provided by a treating physician will be considered by the Board in making a disability decision. A treating physician is a doctor to whom the claimant has been going for treatment on a continuing basis. The claimant may have more than one treating physician. The Board may use consulting physicians or other medical consultants for specialized examinations or tests, to obtain more complete evidence, and to resolve any conflicts. A consulting physician is a doctor (often a specialist) to whom the claimant is referred for an examination once or on a limited basis. (See § 220.50 for an explanation of when the Board may request a consultative examination.)

(e) *Information from other sources.* Information from other sources may also help the Board understand how an impairment affects the claimant's ability to work. Other sources include—

(1) Public and private social welfare agencies;

(2) Observations by nonmedical sources;

(3) Other practitioners (for example, naturopaths, chiropractors, audiologists, etc.); and

(4) Railroad and nonrailroad employers.

(Approved by the Office of Management and Budget under control number 3220–0038)

§ 220.47 Purchase of existing medical evidence.

The Board needs specific medical evidence to determine whether a claimant is disabled. The claimant is responsible for providing that evidence. However, at its discretion, the Board will pay the reasonable cost to obtain medical evidence that it needs and requests from physicians not employed by the Federal government and other non-Federal providers of medical services.

§ 220.48 If the claimant fails to submit medical or other evidence.

The Board may request a claimant to submit medical or other evidence. If the claimant does not submit that evidence, the Board will make a decision on other evidence which is either already available in the claimant's case or which the Board may develop from other sources, including reports of consultative examinations.

Subpart G—Consultative Examinations

§ 220.50 Consultative examinations at the Board's expense.

A consultative examination is a physical or mental examination or test purchased for a claimant at the Board's request and expense. If the claimant's medical sources cannot provide sufficient medical evidence about the claimant's impairment(s) in order to enable the Board to determine whether the claimant is disabled, the Board may ask the claimant to have one or more consultative examinations or tests. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §§ 220.53 through 220.56. Selection of the source for the examination will be consistent with the provisions of § 220.64 (Program Integrity).

(Approved by the Office of Management and Budget under control number 3220–0124)

§ 220.51 Notice of the examination.

If the Board arranges for an examination or test, the claimant will be provided with reasonable notice of the date, time, and place of the examination or test and the name of the person who will do it. The Board will also give the examiner any necessary background information about the claimant's impairment(s).

§ 220.52 Failure to appear at a consultative examination.

(a) *General.* The Board may find that the claimant is not disabled if he or she does not have good reason for failing or refusing to take part in a consultative examination or test which was arranged by the Board. If the individual is already receiving an annuity and does not have a good reason for failing or refusing to take part in a consultative examination or test which the Board arranged, the Board may determine that the individual's disability has stopped because of his or her failure or refusal. The claimant for whom an examination or test has been scheduled should notify the Board as soon as possible before the scheduled date of the examination or test if he or she has any reason why he or she cannot go to the examination or test. If the Board finds that the claimant has a good reason for failure to appear, another examination or test will be scheduled.

(b) *Examples of good reasons for failure to appear.* Some examples of good reasons for not going to a scheduled examination or test include—

(1) Illness on the date of the scheduled examination or test;

(2) Failure to receive notice or timely notice of an examination or test;

(3) Receipt of incorrect or incomplete information about the examination or test; or

(4) A death or serious illness in the claimant's immediate family.

(c) *Objections by a claimant's physician.* The Board should be notified immediately if the claimant is advised by his or her treating physician not to take an examination or test. In some cases, the Board may be able to secure the information which is needed in another way or the treating physician may agree to another type of examination for the same purpose.

§ 220.53 When the Board will purchase a consultative examination and how it will be used.

(a)(1) *General.* The decision to purchase a consultative examination for a claimant will be made after full consideration is given to whether the additional information needed (e.g., clinical findings, laboratory tests, diagnosis, and prognosis, etc.) is readily available from the records of the claimant's medical sources. Upon filing an application for a disability annuity, a claimant will be required to obtain from his or her medical source(s) information regarding the claimed impairments. The Board will seek clarification from a medical source who has provided a report when that report contains a conflict or ambiguity, or does not contain all necessary information or when the information supplied is not based on objective evidence. The Board will not, however, seek clarification from a medical source when it is clear that the source either cannot or will not provide the necessary findings, or cannot reconcile a conflict or ambiguity in the findings provided from the source's records. Therefore, before purchasing a consultative examination, the Board will consider not only existing medical reports, but also the background report containing the claimant's allegations and information about the claimant's vocational background, as well as other pertinent evidence in his or her file.

(2) When the Board purchases a consultative examination, we will use the report from the consultative examination to try to resolve a conflict or ambiguity if one exists. The Board will do this by comparing the persuasiveness and value of the evidence. The Board will also use a consultative examination to secure needed medical evidence the file does not contain such as clinical findings, laboratory tests, a diagnosis or prognosis necessary for decision.

(b) *Situations requiring a consultative examination.* A consultative examination may be purchased when the evidence as a whole, both medical and non-medical, is not sufficient to support a decision on the claim. In addition, other situations, such as one or more of the following, will normally

require a consultative examination (these situations are not all-inclusive):

(1) The specific additional evidence needed for adjudication has been pinpointed and high probability exists for obtaining it through purchase.

(2) The additional evidence needed is not contained in the records of the claimant's treating sources.

(3) Evidence that may be needed from the claimant's treating or other medical sources cannot be obtained for reasons beyond his or her control, such as death or noncooperation of the medical source.

(4) Highly technical or specialized medical evidence which is needed is not available from the claimant's treating sources.

(5) A conflict, inconsistency, ambiguity or insufficiency in the evidence must be resolved.

(6) There is an indication of a change in the claimant's condition that is likely to affect his or her ability to function, but current severity is not documented.

(7) Information provided by any source appears not to be supported by objective evidence.

§ 220.54 When the Board will not purchase a consultative examination.

A consultative examination will not be purchased in the following situations (these situations are not all-inclusive):

(a) In disabled widow(er) benefit claims, when the alleged month of disability is after the end of the 7-year period specified in § 216.38 and there is no possibility of establishing an earlier onset, or when the 7-year period expired in the past and all the medical evidence in the claimant's file establishes that he or she was not disabled on or before the expiration date.

(b) When any issues about the actual performance of substantial gainful activity have not been resolved.

(c) In childhood disability claims, when it is determined that the claimant's alleged childhood disability did not begin before the month of attainment of age 22. In this situation, the claimant could not be entitled to benefits as a disabled child unless found disabled before age 22.

(d) When, on the basis of the claimant's allegations and all available medical reports in his or her case file, it is apparent that he or she does not have an impairment which will have more than a minimal effect on his or her capacity to work.

(e) Childhood disability claims filed concurrently with the employee's claim and entitlement cannot be established for the employee.

(f) Survivors childhood disability claims where entitlement is precluded based on non-disability factors.

§ 220.55 Purchase of consultative examinations at the reconsideration level.

(a) When a claimant requests a review of the Board's initial determination at the reconsideration level of review, consultative medical examinations will be obtained when needed, but not routinely. A consultative examination will not, if possible, be performed by the same physician or psychologist used in the initial claim.

(b) Where the evidence tends to substantiate an affirmation of the initial denial but the claimant states that the treating physician or psychologist considers him or her to be disabled, the Board will assist the claimant in securing medical reports or records from the treating physician.

§ 220.56 Securing medical evidence at the hearings officer hearing level.

(a) Where there is a conflict in the medical evidence at the hearing level of review before a hearings officer, the hearings officer will try to resolve it by comparing the persuasiveness and value of the conflicting evidence. The hearings officer's reasoning will be explained in the decision rationale. Where such resolution is not possible, the hearings officer will secure additional medical evidence (e.g., clinical findings, laboratory test, diagnosis, prognosis, etc.) to resolve the conflict. Even in the absence of a conflict, the hearings officer will also secure additional medical evidence when the file does not contain findings, laboratory tests, a diagnosis, or a prognosis necessary for a decision.

(b) Before requesting a consultative examination, the hearings officer will

ascertain whether the information is available as a result of a recent examination by any of the claimant's medical sources. If it is, the hearings officer will request the evidence from that medical practitioner. If contact with the medical source is not productive for any reason, or if there is no recent examination by a medical source, the hearings officer will obtain a consultative examination.

§ 220.57 Types of purchased examinations and selection of sources.

(a) *Additional evidence needed for disability determination.* The types of examinations and tests the Board will purchase depends upon the additional evidence needed for the disability determination. The Board will purchase only the specific evidence needed. For example, if special tests (such as X-rays, blood studies, or EKG) will furnish the additional evidence needed for the disability determination, a more comprehensive medical examination will not be authorized.

(b) *The physician or psychologist selected to do the examination or test must be qualified.* The physician's or psychologist's qualifications must indicate that the physician or psychologist is currently licensed in the State and has the training and experience to perform the type of examination or test requested. The physician or psychologist may use support staff to help perform the examination. Any such support staff must meet appropriate licensing or certification requirements of the State. See also § 220.64.

§ 220.58 Objections to the designated physician or psychologist.

A claimant or his or her representative may object to his or her being examined by a designated physician or psychologist. If there is a good reason for the objection, the Board will schedule the examination with another physician or psychologist. A good reason may be where the consultative examination physician or psychologist had previously represented an interest adverse to the claimant. For example, the physician or psychologist may have represented the claimant's employer in a worker's compensation case or may have been involved in an insurance claim or legal action adverse to the claimant. Other things the Board will consider are: language barrier, office location of consultative examination physician or psychologist (2nd floor, no elevator, etc.), travel restrictions, and examination by the physician or psychologist in connection with a previous unfavorable determination. If the objection is because a physician or psychologist allegedly ''lacks objectivity'' (in general, but not in relation to the claimant personally) the Board will review the allegations. To avoid a delay in processing the claimant's claim, the consultative examination in such a case will be changed to another physician or psychologist while a review is being conducted. Any objection to use of the substitute physician or psychologist will be handled in the same manner. However, if the Board or the Social Security Administration had previously conducted such a review and found that the reports of the consultative physician or psychologist in question conform to the Board's guidelines, then the Board will not change the claimant's examination.

§ 220.59 Requesting examination by a specific physician, psychologist or institution—hearings officer hearing level.

In an unusual case, a hearings officer may have reason to request an examination by a particular physician, psychologist or institution. Some examples include the following:

(a) Conflicts in the existing medical evidence require resolution by a recognized authority in a particular specialty:

(b) The impairment requires hospitalization for diagnostic purposes; or

(c) The claimant's treating physician or psychologist is in the best position to submit a meaningful report.

§ 220.60 Diagnostic surgical procedures.

The Board will not order diagnostic surgical procedures such as myelograms and arteriograms for the evaluation of disability under the Board's disability program. In addition, the Board

will not order procedures such as cardiac catheterization and surgical biopsy. However, if any of these procedures have been performed as part of a workup by the claimant's treating physician or other medical source, the results may be secured and used to help evaluate an impairment(s)'s severity.

§ 220.61 Informing the examining physician or psychologist of examination scheduling, report content and signature requirements.

Consulting physicians or psychologists will be fully informed at the time the Board contacts them of the following obligations:

(a) *General.* In scheduling full consultative examinations, sufficient time should be allowed to permit the examining physician to take a case history and perform the examination (including any needed tests).

(b) *Report content.* The reported results of the claimant's medical history, examination, pertinent requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help the Board determine the nature, severity, duration of the impairment, and residual functional capacity. Pertinent points in the claimant's medical history, such as a description of chest pain, will reflect the claimant's statements of his or her symptoms, not simply the physician's or psychologist's statements or conclusions. The examining physician's or psychologist's report of the consultative examination will include the objective medical facts.

(c) *Elements of a complete examination.* A complete examination is one which involves all the elements of a standard examination in the applicable medical specialty. When a complete examination is involved, the report will include the following elements:

(1) The claimant's major or chief complaint(s).

(2) A detailed description, within the area of speciality of the examination, of the history of the claimant's major complaint(s).

(3) A description, and disposition, of pertinent ''positive,'' as well as ''negative,'' detailed findings based on the history, examination and laboratory test(s) related to the major complaint(s) and any other abnormalities reported or found during examination or laboratory testing.

(4) The results of laboratory and other tests (e.g., x-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of this part).

(5) The diagnosis and prognosis for the claimant's impairment(s).

(6) A statement as to what the claimant can still do despite his or her impairment(s) (except in disability claims for remarried widows and widowers, and surviving divorced spouses). This statement must describe the consultative physician's or psychologist's opinion concerning the claimant's ability, despite his or her impairment(s), to do basic work activities such as sitting, standing, lifting, carrying, handling objects, hearing, speaking, and traveling: and, in cases of mental impairment(s), the consultative physician's or psychologist's opinion as to the claimant's ability to reason or make occupational, personal, or social adjustments.

(7) When less than a complete examination is required (for example, a specific test or study is needed), not every element is required.

(d) *Signature requirements.* All consultative examination reports will be personally reviewed and signed by the physician or psychologist who actually performed the examination. This attests to the fact that the physician or psychologist doing the examination or

testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory test results.

§ 220.62 Reviewing reports of consultative examinations.

(a) The Board will review the report of the consultative examination to determine whether the specific information requested has been furnished. The Board will consider these factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decision-making in terms of the impairment it assesses.

(2) Whether the report is internally consistent. Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the physical findings. Whether the conclusions correlate the findings from the claimant's medical history, physical examination and laboratory tests and explain all abnormalities.

(3) Whether the report is consistent with the other information available to the Board within the specialty of the examination requested. Whether the report fails to mention an important or relevant complaint within the speciality that is noted on other evidence in the file (e.g., blindness in one eye, amputations, flail limbs or claw hands, etc.).

(4) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, the Board will contact the examining consultative physician or psychologist, give an explanation of the Board's evidentiary needs, and ask that the physician or psychologist furnish the missing information or prepare a revised report.

(c) Where the examination discloses new diagnostic information or test results which are significant to the claimant's treatment, the Board will consider referral of the consultative examination report to the claimant's treating physician or psychologist.

(d) The Board will take steps to ensure that consultative examinations are scheduled only with medical sources who have the equipment required to provide an adequate assessment and record of the level of severity of the claimant's alleged impairments.

§ 220.63 Conflict of interest.

All implications of possible conflict of interest between Board medical consultants and their medical practices will be avoided. Board review physicians or psychologists will not perform consultative examinations for the Board's disability programs without prior approval. In addition, they will not acquire or maintain, directly or indirectly, including any member of their families, any financial interest in a medical partnership or similar relationship in which consultative examinations are provided. Sometimes one of the Board's review physicians or psychologists will have prior knowledge of a case (e.g., the claimant was a patient). Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on prior treatment or examination of the claimant.

§ 220.64 Program integrity.

The Board will not use in its program any individual or entity who is excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; who has been convicted, under Federal or State law, in connection with the delivery of health care services, of fraud, theft, embezzlement, breach of fiduciary responsibility or financial abuse; who has been convicted under Federal or State law of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; whose license to provide health care services is revoked or suspended by any State licensing authority for reasons bearing on professional competence, professional conduct, or financial integrity; who has surrendered such a license while formal disciplinary proceedings involving professional conduct were pending; or who has had a civil monetary assessment or penalty imposed on such individual or entity

for any activity described in this section or as a result of formal disciplinary proceedings. Also see §§ 220.53 and 220.57(b).

Subpart H—Evaluation of Disability

§ 220.100 Evaluation of disability for any regular employment.

(a) *General.* The Board uses a set evaluation process, explained in paragraph (b) of this section, to determine whether a claimant is disabled for any regular employment. This evaluation process applies to employees, widow(er)s, and children who have applied for annuities under the Railroad Retirement Act based on disability for any regular employment. Regular employment means substantial gainful activity as that term is defined in § 220.141.

(b) *Steps in evaluating disability.* A set order is followed to determine whether disability exists. The duration requirement, as described in § 220.28, must be met for a claimant to be found disabled. The Board reviews any current work activity, the severity of the claimant's impairment(s), the claimant's residual functional capacity, and the claimant's age, education, and work experience. If the Board finds that the claimant is disabled or is not disabled at any step in the process, the Board does not review further. (See § 220.105 if the claimant is not currently disabled but was previously disabled for a specified period of time in the past.) The steps are as follows:

(1) *Claimant is working.* If the claimant is working, and the work is substantial gainful activity, the Board will find that he or she is not disabled regardless of his or her impairments, age, education, or work experience. If the claimant is not performing substantial gainful activity, the Board will follow paragraph (2) of this section.

(2) *Impairment(s) not severe.* If the claimant does not have an impairment or combination of impairments which significantly limit his or her physical or mental ability to do basic work activities, the Board will find that the claimant is not disabled without consideration of age, education, or work experience. If the claimant has an impairment or combination of impairments which significantly limit his or her ability to do basic work activities, the Board will follow paragraph (3) of this section. (See § 220.102(b) for a definition of basic work activities.)

(3) *Impairment(s) meets or equals one in the Listing of Impairments.* If the claimant has an impairment or combination of impairments which meets the duration requirement and such impairment is listed or is medically equal to one which is listed in the Listing of Impairments, the Board will find the claimant disabled without considering his or her age, education or work experience. (The Listing of Impairments is contained in appendix 1 of this part.) If the claimant's impairment or combination of impairments is not listed or is not medically equal to one which is listed in the Listing of Impairments, the Board will follow paragraph (4) of this section. (Medical equivalence is discussed in § 220.111).

(4) *Impairment(s) must prevent past relevant work.* If the claimant's impairment or combination of impairments is not listed or is not medically equal to one which is listed in the Listing of Impairments, the Board will then review the claimant's residual functional capacity (see § 220.120) and the physical and mental demands of past relevant work (see § 220.130). If the Board determines that the claimant is still able to do his or her past relevant work, the Board will find that he or she is not disabled. If the claimant is unable to do his or her past relevant work, the Board will follow paragraph (5) of this section.

(5) *Impairment(s) must prevent any other work.* (i) If the claimant is unable to do his or her past relevant work because of his or her impairment or combination of impairments, the Board will review the claimant's residual functional capacity and his or her age, education and work experience to determine if the claimant is able to do any other work. If the claimant cannot do other work, the Board will find him or her disabled. If the claimant can do other work, the Board will find the claimant not disabled.

(ii) If the claimant has only a marginal education (see § 220.129) and long work experience (i.e., 35 years or more)

in which he or she only did arduous unskilled physical labor, and the claimant can no longer do this kind of work, the Board will use a different rule (see § 220.127) to determine disability.

(c) Once a claimant has been found eligible to receive a disability annuity, the Board follows a somewhat different order of evaluation to determine whether the claimant's eligibility continues as explained in § 220.180.

§ 220.101 Evaluation of mental impairments.

(a) *General.* The steps outlined in § 220.100 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of a mental impairment(s), the Board will follow a special procedure at each administrative level of review. Following this procedure will assist the Board in—

(1) Identifying additional evidence necessary for the determination of impairment severity;

(2) Considering and evaluating aspects of the mental impairment(s) relevant to the claimant's ability to work; and

(3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.* (1) This procedure requires the Board to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in the claimant's case record. This will assist the Board in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See § 220.27 for further information about what is needed to show an impairment.)

(2) If the Board determines that a mental impairment(s) exists, this procedure then requires the Board to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires the Board to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by the Board as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions.

For the first two areas (activities of daily living and social functioning), the rating is done based upon the following five-point scale; none, slight, moderate, marked, and extreme. For the third area (concentration, persistence, or pace), the following five-point scale is used: never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four-point scale is used: never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represent a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment(s), the Board then determines the severity of the mental impairment(s).

(1) If the four areas considered by the Board as essential to work have been rated to indicate a degree of limitation as ''none'' or ''slight'' in the first and second area, ''never'' or ''seldom'' in the third area, and ''never'' in the fourth area, the Board can generally conclude that the impairment(s) is not severe, unless the evidence otherwise indicates that there is significant limitation of the claimant's mental ability to do basic work activities (see § 220.102).

(2) If the claimant's mental impairment(s) is severe, the Board must then determine if it meets or equals a listed mental impairment. This is done by comparing the Board's prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by the Board as especially relevant to a claimant's ability to

work and the Board's rating of functional loss resulting from the mental impairment(s)) against the criteria of the appropriate listed mental disorder(s).

(3) If the claimant has a severe impairment(s), but the impairment(s) neither meets nor equals the Listings, the Board will then do a residual functional capacity assessment for those claimants (employees, widow(er)s, and children) whose applications are based on disability for any regular employment under the Railroad Retirement Act.

(4) At all adjudicative levels, the Board will, in each case, incorporate the pertinent findings and conclusions based on this procedure in its decision rationale. The Board's rationale must show the significant history, including examination, laboratory findings, and functional limitations that the Board considered in reaching conclusions about the severity of the mental impairment(s).

§ 220.102 Non-severe impairment(s), defined.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit the claimant's physical or mental ability to do basic work activities.

(b) *Basic work activities.* Basic work activities means the ability and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

§ 220.103 Two or more unrelated impairments—initial claims.

(a) *Unrelated severe impairments.* Two or more unrelated severe impairments cannot be combined to meet the 12-month duration test. If the claimant has a severe impairment(s) and then develops another unrelated severe impairment(s) but neither one is expected to last for 12 months, he or she cannot be found disabled even though the 2 impairments in combination last for 12 months.

(b) *Concurrent impairments.* If the claimant has 2 or more concurrent impairments which, when considered in combination, are severe, the board must also determine whether the combined effect of the impairments can be expected to continue to be severe for 12 months. If 1 or more of the claimant's impairments improves or is expected to improve within 12 months, so that the combined effect of the claimant's impairments is no longer severe, he or she will be found to not meet the 12-month duration test.

§ 220.104 Multiple impairments.

To determine whether the claimant's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligiblity under the law, the combined effect of all of the claimant's impairments are considered regardless of whether any such impairment, if considered separately, would be of sufficient severity. If a medically severe combination of impairments is found, it will be considered throughout the disability evaluation process. If a medically severe combination of impairments is not found, the claimant will be determined to be not disabled.

§ 220.105 Initial evaluation of a previous disability.

(a) In some cases, the Board may determine that a claimant is not currently disabled but was previously disabled for a specified period of time in the past. This can occur when—

(1) The disability application was filed before the claimant's disability ended but the Board did not make the initial determination of disability until after the claimant's disability ended; or

(2) The disability application was filed after the claimant's disability ended but no later than the 12th month after the month the disability ended.

(b) When evaluating a claim for a previous disability, the Board follows the steps in § 220.100 to determine whether a disability existed, and follows the steps in § 220.180 to determine when the disability ended.

Example 1. The claimant sustained multiple fractures to his left leg in an automobile accident which occurred on June 16, 1982. For a period of 18 months following the accident the claimant underwent 2 surgical procedures which restored the functional use of his leg. After a recovery period following the last surgery, the claimant returned to work on February 1, 1984.

The claimant, although fully recovered medically and regularly employed, filed an application on December 3, 1984 for a determination of disability for the period June 16, 1982 through January 31, 1984. The Board reviewed his claim in January 1985 and determined that he was disabled for the prior period which began June 16, 1982 and continued through January 31, 1984. A disability annuity is payable to the employee only for the period December 1, 1983 through January 31, 1984.

An annuity may not begin any earlier than the 1st of the 12th month before the month in which the application was filed (See part 218 of this chapter for the rules on when an annuity may begin).

Example 2: The claimant is disabled using the same medical facts disclosed above, beginning June 16, 1982 (the date of the automobile accident). The claimant files an application for a disability annuity, dated December 1, 1983. However, as of February 1, 1984, and before the Board makes a disability determination, the claimant returns to full-time work and is no longer considered disabled. The Board reviews the claimant's application in May 1984 and finds him disabled for the period June 16, 1982 through January 31, 1984. A disability annuity is payable to the employee from December 1, 1982 through January 31, 1984. (See part 218 of this chapter for the rules on when an annuity may begin).

Subpart I—Medical Considerations

§ 220.110 Listing of Impairments in appendix 1 of this part.

(a) *Purpose of the Listing of Impairments.* The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any substantial gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

(b) *Adult and childhood listings.* The Listing of Impairments consists of two parts:

(1) *Part A* contains medical criteria that apply to claimants age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in claimants under age 18 if the disease processes have a similar effect on adults and younger persons.

(2) *Part B* contains additional medical criteria that apply only to the evaluation of impairments of disabled children who are between the ages of 16 and 18. Certain criteria in part A do not give appropriate consideration to the particular effects of the disease processes in childhood: i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Additional criteria are included in part B, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in part A. In evaluating disability for a child between 16 and 18, part B will be used first. If the medical criteria in part B do not apply, then the medical criteria in part A will be used.

(c) *How to use the Listing of Impairments.* Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are required in establishing a diagnosis or in confirming the existence of the impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the Listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory techniques. Following the introduction in each section, the required level of severity of impairment is shown under ''Category of Impairments'' by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

(d) *Diagnosis of impairments.* The Board will not consider the claimant's impairment to be one listed in appendix 1 of this part solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing of that impairment.

(e) *Addiction to alcohol or drugs.* If a claimant has a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether the claimant is, or is not, disabled. As with any other medical condition, the Board will decide whether the claimant is disabled based on symptoms, signs, and laboratory findings.

(f) *Symptoms as criteria of listed impairment(s).* Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are present.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 60291, Oct. 22, 2003]

§ 220.111 Medical equivalence.

(a) *How medical equivalence is determined.* The Board will decide that the claimant's impairment(s) is medically equivalent to a listed impairment in appendix 1 of this part if the medical findings are at least equal in severity and duration to the listed findings. The Board compares the symptoms, signs, and laboratory findings about the claimant's impairment(s), as shown in the medical evidence in his or her claim, with the medical criteria shown with the listed impairment. If the claimant's impairment is not listed, the Board will consider the listed impairment most like the claimant's impairment to decide whether his or her impairment is medically equal. If the claimant has more than one impairment, and none of them meets or equals a listed impairment, the Board will review the symptoms, signs, and laboratory findings about the claimant's impairments to determine whether the combination of his or her impairments is medically equal to any listed impairment.

(b) *Medical equivalence must be based on medical findings.* The Board will base its decision about whether the claimant's impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. The Board will also consider the medical opinion given by one or more physicians employed or engaged by the Board or the Social Security Administration to make medical judgments.

§ 220.112 Conclusions by physicians concerning the claimant's disability.

(a) *General.* Under the statute, the Board is responsible for making the decision about whether a claimant meets the statutory definition of disability. A claimant can only be found disabled if he or she is unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See § 220.28). A claimant's impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. (See § 220.27). The decision as to whether a claimant is disabled may involve more than medical considerations and the Board may have to consider such factors as age, education and past work experience. Such vocational factors are not within the expertise of medical sources.

(b) *Medical opinions that are conclusive.* A medical opinion by a treating source will be conclusive as to the medical issues of the nature and severity of a claimant's impairment(s) where the Board finds that (1) it is fully supported by medically acceptable clinical and laboratory diagnostic techniques and (2) it is not inconsistent with the other substantial medical evidence of record. A medical opinion that

is not fully supported will not be conclusive.

(c) *Medical opinions that are not fully supported.* If an opinion by a treating source(s) is not fully supported, the Board will make every reasonable effort (i.e., an initial request and, after 20 days, one follow-up request) to obtain from the claimant's treating source(s) the relevant evidence that supports the medical opinion(s) before the Board makes a determination as to whether a claimant is disabled.

Example: In a case involving an organic mental disorder caused by trauma to the head, a consultative physician, upon interview with the claimant, found only mild disorientation as to time and place. The claimant's treating physician reports that the claimant, as the result of his impairment, has severe disorientation as to time and place. The treating physician supplies office notes which follow the course of the claimant's illness from the date of injury to the present. These notes indicate that the claimant's condition is such that he has some ''good days'' on which he appears to be unimpaired, but generally support the treating physician's opinion that the claimant is severely impaired. In this case the treating physician's opinion will be given some weight over that of the consultative physician.

(d) *Inconsistent medical opinions.* Where the Board finds that the opinion of a treating source regarding medical issues is inconsistent with the evidence of record, including opinions of other sources that are supported by medically acceptable clinical and laboratory diagnostic techniques, the Board must resolve the inconsistency. If necessary to resolve the inconsistency, the Board will secure additional independent evidence and/or further interpretation or explanation from the treating source(s) and/or the consultative physician or psychologist. The Board's determination will be based on all the evidence in the case record, including the opinions of the medical sources. In resolving an inconsistency, the Board will give some extra weight to the treating source's supported opinion(s) which interprets the medical findings about the nature and severity of the impairment(s).

Example: In a case involving arthritis of the shoulder, where the X-rays confirm bone destruction, the examinations indicate minimal swelling and inflammation, but the treating source supplies evidence of greater restriction in the range of motion than found by the consultative physician, the Board will ask the treating source for further interpretation of the range of motion studies. If the treating source supplies a reasonable explanation. e.g., that the individual's condition is subject to periods of aggravation, the treating source's explanation will be given some extra weight over that of the consultative physician.

(e) *Medical opinions that will not be considered conclusive nor given extra weight.* The Board will not consider as conclusive nor give extra weight to medical opinions which are not in accord with the statutory or regulatory standards for establishing disability. Thus, opinions that the individual's impairments meet the Listing of Impairments in appendix 1 of this part, where the medical findings which are the basis for that conclusion would not meet the specific criteria applicable to the particular impairment as set out in the Listing will not be conclusive nor given extra weight. Likewise, an opinion(s) as to the individual's residual functional capacity which is not in accord with regulatory requirements set forth in §§ 220.120 and 220.121 will not be conclusive nor given extra weight.

Example 1: A medical opinion that an impairment meets listing 2.02 but the medical findings show that the individual's visual acuity in the better eye after best correction is 20/100, would not be conclusive nor would it be given extra weight since listing 2.02 requires that the remaining vision in the better eye after best correction be 20/200 or less.

Example 2: A medical opinion that the individual is limited to light work when the evidence shows that he or she can lift a maximum of 50 pounds and lift 25 pounds frequently will not be considered as conclusive nor given extra weight. This is because the individual's exertional capacity exceeds the criteria set forth in the regulations for light work.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 60291, Oct. 22, 2003]

§ 220.113 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are the claimant's own description of his or her physical or mental impairment(s). The claimant's

statements alone are not enough to establish that there is a physical or mental impairment(s).

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from the claimant's own statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.) x-rays, and psychological tests.

§ 220.114 Evaluation of symptoms, including pain.

(a) *General.* In determining whether the claimant is disabled, the Board considers all of the claimant's symptoms, including pain, and the extent to which the claimant's symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. By objective medical evidence, the Board means medical signs and laboratory findings as defined in §§ 220.113(b) and (c) of this part. By other evidence, the Board means the kinds of evidence described in §§ 220.45 and 220.46 of this part. These include statements or reports from the claimant, the claimant's treating or examining physician or psychologist, and others about the claimant's medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how the claimant's impairment(s) and any related symptoms affect the claimant's ability to work. The Board will consider all of the claimant's statements about his or her symptoms, such as pain, and any description by the claimant, the claimant's physician, or psychologist, or other persons about how the symptoms affect the claimant's activities of daily living and ability to work. However, statements alone about the claimant's pain or other symptoms will not establish that the claimant is disabled; there must be medical signs and laboratory findings which show that the claimant has a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of the claimant's pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that the claimant is disabled. In evaluating the intensity and persistence of the claimant's symptoms, including pain, the Board will consider all of the available evidence, including the claimant's medical history, the medical signs and laboratory findings and statements about how the claimant's symptoms affect the claimant. (Section 220.112(b) of this part explains how the Board considers opinions of the claimant's treating source and other medical opinions on the existence and severity of the claimant's symptoms, such as pain.) The Board will then determine the extent to which the claimant's alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how the claimant's symptoms affect the claimant's ability to work.

(b) *Need for medically determinable impairment that could reasonably be expected to produce symptoms, such as pain.* The claimant's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect the claimant's ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical,

physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. The finding that the claimant's impairment(s) could reasonably be expected to produce the claimant's pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of the claimant's symptoms. The Board will develop evidence regarding the possibility of a medically determinable mental impairment when the Board has information to suggest that such an impairment exists, and the claimant alleges pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of symptoms, such as pain, and determining the extent to which the claimant's symptoms limit his or her capacity for work.*—(1) *General.* When the medical signs or laboratory findings show that the claimant has a medically determinable impairment(s) that could reasonably be expected to produce the claimant's symptoms, such as pain, the Board must then evaluate the intensity and persistence of the claimant's symptoms so that it can determine how the claimant's symptoms limit the claimant's capacity for work. In evaluating the intensity and persistence of the claimant's symptoms, the Board considers all of the available evidence, including the claimant's medical history, the medical signs and laboratory findings, and statements from the claimant, the claimant's treating or examining physician or psychologist, or other persons about how the claimant's symptoms affect the claimant. The Board also considers the medical opinions of the claimant's treating source and other medical opinions as explained in § 220.112 of this part. Paragraphs (c)(2) through (c)(4) of this section explain further how the Board evaluates the intensity and persistence of the claimant's symptoms and how it determines the extent to which the claimant's symptoms limit the claimant's capacity for work, when the medical signs or laboratory findings show that the claimant has a medically determinable impairment(s) that could reasonably be expected to produce the claimant's symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist the Board in making reasonable conclusions about the intensity and persistence of the claimant's symptoms and the effect those symptoms, such as pain, may have on the claimant's ability to work. The Board must always attempt to obtain objective medical evidence and, when it is obtained, the Board will consider it in reaching a conclusion as to whether the claimant is disabled. However, the Board will not reject the claimant's statements about the intensity and persistence of the claimant's pain or other symptoms or about the effect the claimant's symptoms have on the claimant's ability to work solely because the available objective medical evidence does not substantiate the claimant's statements.

(3) *Consideration of other evidence.* Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, the Board will carefully consider any other information the claimant may submit about his or her symptoms. The information that the claimant, the claimant's treating or examining physician or psychologist, or other persons provide about the claimant's pain or other symptoms (*e.g.,* what may precipitate or aggravate the claimant's symptoms, what medications, treatments or other methods he or she uses to alleviate them, and how the symptoms may affect the claimant's pattern of daily living) is also an important indicator of the intensity and persistence of the claimant's symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which the claimant, his or her treating or examining physician or psychologist, or other persons report,

which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether the claimant is disabled. The Board will consider all of the evidence presented, including information about the claimant's prior work record, the claimant's statements about his or her symptoms, evidence submitted by the claimant's treating, examining or consulting physician or psychologist, and observations by Board employees and other persons. Section 220.112 of this part explains in detail how the Board considers and weighs treating source and other medical opinions about the nature and severity of the claimant's impairment(s) and any related symptoms, such as pain. Factors relevant to the claimant's symptoms, such as pain, which the Board will consider include:

(i) The claimant's daily activities;

(ii) The location, duration, frequency, and intensity of the claimant's pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication the claimant takes or has taken to alleviate the claimant's pain or other symptoms;

(v) Treatment, other than medication, the claimant receives or has received for relief of pain or other symptoms;

(vi) Any measures the claimant uses or has used to relieve pain or other symptoms (*e.g.,* lying flat on the claimant's back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning the claimant's functional limitations and restrictions due to pain or other symptoms.

(4) *How the Board determines the extent to which symptoms, such as pain, affect the claimant's capacity to perform basic work activities.* In determining the extent to which the claimant's symptoms, such as pain, affect the claimant's capacity to perform basic work activities, the Board considers all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. The Board will consider the claimant's statements about the intensity, persistence, and limiting effects of the claimant's symptoms, and the Board will evaluate the claimant's statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether the claimant is disabled. The Board will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between the claimant's statements and the rest of the evidence, including the claimant's medical history, the medical signs and laboratory findings, and statements by the claimant's treating or examining physician or psychologist or other persons about how the claimant's symptoms affect the claimant. The claimant's symptoms, including pain, will be determined to diminish the claimant's capacity for basic work activities to the extent that the claimant's alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* The Board follows a set order of steps to determine whether the claimant is disabled. If the claimant is not doing substantial gainful activity, the Board considers the claimant's symptoms, such as pain, to evaluate whether the claimant has a severe physical or mental impairment(s), and at each of the remaining steps in the process. Section 220.100 explains this process in detail. The Board also considers the claimant's symptoms, such as pain, at the appropriate steps in the Board's review when the Board considers whether the claimant's disability continues. Subpart O of this part explains the procedure the Board follows in reviewing whether the claimant's disability continues.

(1) *Need to establish a severe medically determinable impairment(s).* The claimant's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether the claimant's impairment or combination of impairment(s) is severe. (*See* § 220.100(b)(2) of this part).

(2) *Decision whether the Listing of Impairments is met.* Some listed impairment(s) include symptoms, such as pain, as criteria. Section 220.100(f) of this part explains how the Board considers the claimant's symptoms when the claimant's symptoms are included as criteria for a listed impairment.

(3) *Decision whether the Listing of Impairments is equaled.* If the claimant's impairment is not the same as a listed impairment, the Board must determine whether the claimant's impairment(s) is medically equivalent to a listed impairment. Section 220.111 of this part explains how the Board makes this determination. Under § 220.111(b) of this part, the Board will consider equivalence based on medical evidence only. In considering whether the claimant's symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, the Board will look to see whether the claimant's symptoms, signs, and laboratory findings are at least equal in severity to the listed criteria. However, the Board will not substitute the claimant's allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of the claimant's impairment(s) to that of a listed impairment. If the symptoms, signs, and laboratory findings of the claimant's impairment(s) are equivalent in severity to those of a listed impairment, the Board will find the claimant disabled. If it does not, the Board will consider the impact of the claimant's symptoms on the claimant's residual functional capacity. (*See* paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity.* If the claimant has a medically determinable severe physical or mental impairment(s), but the claimant's impairment(s) does not meet or equal an impairment listed in Appendix 1 of this part, the Board will consider the impact of the claimant's impairment(s) and any related symptoms, including pain, on the claimant's residual functional capacity. (*See* § 220.120 of this part.)

[68 FR 60291, Oct. 22, 2003]

§ 220.115 Need to follow prescribed treatment.

(a) *What treatment the claimant must follow.* In order to get a disability annuity, the claimant must follow treatment prescribed by his or her physician if this treatment can restore the claimant's ability to work.

(b) *When the claimant does not follow prescribed treatment.* If the claimant does not follow the prescribed treatment without a good reason, the Board will find him or her not disabled or, if the claimant is already receiving a disability annuity, the Board will stop paying the annuity.

(c) *Acceptable reasons for failure to follow prescribed treatment.* The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of the claimant's religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through surgery.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g., open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for the claimant.

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

Subpart J—Residual Functional Capacity

§ 220.120 The claimant's residual functional capacity.

(a) *General.* The claimant's impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what the claimant can do in a work setting. The claimant's residual functional capacity is what the claimant can still do despite the claimant's limitations. If the claimant has more than one impairment, the Board will consider all of the claimant's impairment(s) of which

the Board is aware. The Board will consider the claimant's ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements, and other functions, as described in paragraphs (b), (c), and (d) of this section. Residual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even the claimant's own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of the claimant's medical condition. Observations by the claimant's treating or examining physicians or psychologists, the claimant's family, neighbors, friends, or other persons, of the claimant's limitations, in addition to those observations usually made during formal medical examinations, may also be used. These descriptions and observations, when used, must be considered along with the claimant's medical records to enable us to decide to what extent the claimant's impairment(s) keeps the claimant from performing particular work activities. This assessment of the claimant's remaining capacity for work is not a decision on whether the claimant is disabled, but is used as the basis for determining the particular types of work the claimant may be able to do despite the claimant's impairment(s). Then, using the guidelines in §§ 220.125 and 220.134 of this part the claimant's vocational background is considered along with the claimant's residual functional capacity in arriving at a disability determination or decision. In deciding whether the claimant's disability continues or ends, the residual functional capacity assessment may also be used to determine whether any medical improvement the claimant has experienced is related to the claimant's ability to work as discussed in § 220.178 of this part.

(b) *Physical abilities.* When the Board assesses the claimant's physical abilities, the Board first assesses the nature and extent of the claimant's physical limitations and then determines the claimant's residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce the claimant's ability to do past work and other work.

(c) *Mental abilities.* When the Board assesses the claimant's mental abilities, the Board first assesses the nature and extent of the claimant's mental limitations and restrictions and then determines the claimant's residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce the claimant's ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If the claimant has this type of impairment(s), the Board considers any resulting limitations and restrictions which may reduce the claimant's ability to do past work and other work in deciding the claimant's residual functional capacity.

(e) *Total limiting effects.* When the claimant has a severe impairment(s), but the claimant's symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in Appendix 1 of this part, the Board will consider the limiting effects of all of the claimant's impairment(s), even those that are not severe, in determining the claimant's residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; *e.g.,* someone with a low back disorder may be fully capable of the physical demands

consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of the claimant's impairment(s) and any related symptoms, the Board will consider all of the medical and nonmedical evidence, including the information described in § 220.114 of this part.

[68 FR 60293, Oct. 22, 2003]

§ 220.121 Responsibility for assessing and determining residual functional capacity.

(a) For cases at the initial or reconsideration level, the responsibility for determining residual functional capacity rests with the bureau of retirement claims. This assessment is based on all the evidence the Board has, including any statements regarding what the claimant can still do that have been provided by treating or examining physicians, consultative physicians, or any other physician designated by the Board. In any case where there is evidence which indicates the existence of a mental impairment, the bureau of retirement claims will not make a residual functional capacity determination without making every reasonable effort to ensure that a qualified psychiatrist or psychologist has provided a medical review of the case.

(b) For cases at the hearing level or the three-member-Board review level, the responsibility for deciding residual functional capacity rests with the hearings officer or the three-member Board, respectively.

Subpart K—Vocational Considerations

§ 220.125 When vocational background is considered.

(a) *General.* The Board will consider vocational factors when the claimant is applying for—

(1) An employee annuity based on disability for any regular employment; (See § 220.45(b))

(2) Widow(er) disability annuity; or

(3) Child's disability annuity based on disability before age 22.

(b) *Disability determinations in which vocational factors must be considered along with medical evidence.* When the Board cannot decide whether the claimant is disabled on medical evidence alone, the Board must use other evidence.

(1) The Board will use information from the claimant about his or her age, education, and work experience.

(2) The Board will consider the doctors' reports, and hospital records, as well as the claimant's own statements and other evidence to determine a claimant's residual functional capacity and how it affects the work the claimant can do. Sometimes, to do this, the Board will need to ask the claimant to have special examinations or tests. (See § 220.50.)

(3) If the Board finds that the claimant can no longer do the work he or she has done in the past, the Board will determine whether the claimant can do other work (jobs) which exist in significant numbers in the national economy.

§ 220.126 Relationship of ability to do work and residual functional capacity.

(a) If the claimant can do his or her previous work (his or her usual work or other applicable past work), the Board will determine he or she is not disabled.

(b) If the residual functional capacity is not enough for the claimant to do any of his or her previous work, the Board must still decide if the claimant can do any other work. To determine whether the claimant can do other work, the Board will consider the claimant's residual functional capacity, and his or her age, education, and work experience. Any work (jobs) that the claimant can do must exist in significant numbers in the national economy (either in the region where he or she lives or in several regions of the country).

§ 220.127 When the only work experience is arduous unskilled physical labor.

(a) *Arduous work.* Arduous work is primarily physical work requiring a high level of strength or endurance. The Board will consider the claimant

unable to do lighter work and therefore, disabled if he or she has—

(1) A marginal education (see § 220.129);

(2) Work experience of 35 years or more during which he or she did arduous unskilled physical labor; and

(3) A severe impairment which no longer allows him or her to do arduous unskilled physical labor.

(b) *Exceptions.* The Board may consider the claimant not disabled if—

(1) The claimant is working or has worked despite his or her impairment(s) (except where work is sporadic or not medically advisable); or

(2) Evidence shows that the claimant has training or past work experience which enables him or her to do substantial gainful activity in another occupation with his or her impairment, either full-time or on reasonably regular part-time basis.

Example: B is a 60-year-old miner with a 4th grade education who has a life-long history of arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not show that he has skills or capabilities needed to do lighter work which would be readily transferable to another work setting. Under these circumstances, the Board will find that B is disabled.

§ 220.128 Age as a vocational factor.

(a) *General.* (1) *Age* refers to how old the claimaint is (chronological age) and the extent to which his or her age affects his or her ability to—

(i) Adapt to a new work situation; and

(ii) Do work in competition with others.

(2) In determining disability, the Board does not consider age alone. The Board must also consider the claimant's residual functional capacity, education, and work experience. If the claimant is unemployed because of his or her age and can still do a significant number of jobs which exist in the national economy, the Board will find that he or she is not disabled. Appendix 2 of this part explains in detail how the Board considers age as a vocational factor. However, the Board does not apply these age categories mechanically in a borderline situation.

(b) *Younger person.* If the claimant is under age 50, the Board generally does not consider that his or her age will seriously affect the ability to adapt to a new work situation. In some circumstances, the Board considers age 45 a handicap in adapting to a new work setting (see Rule 201.17 in appendix 2 of this part).

(c) *Person approaching advanced age.* If the claimant is closely approaching advanced age (50–54), the Board considers that the claimant's age, along with a severe impairment and limited work experience, may seriously affect the claimant's ability to adjust to a significant number of jobs in the national economy.

(d) *Person of advanced age.* The Board considers that advanced age (55 or over) is the point at which age significantly affects the claimant's ability to do substantial gainful activity.

(1) If the claimant is severly impaired and of advanced age, and he or she cannot do medium work (see § 220.132), the claimant may not be able to work unless he or she has skills that can be used in less demanding jobs which exist in significant numbers in the national economy.

(2) If the claimant is close to retirement age (60–64) and has a severe impairment, the Board will not consider him or her able to adjust to sedentary or light work unless the claimant has skills which are highly marketable.

§ 220.129 Education as a vocational factor.

(a) *General.* ''Education'' is primarily used to mean formal schooling or other training which contributes to the claimant's ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. If the claimant does not have formal schooling, this does not necessarily mean that the claimant is uneducated or lacks these abilities. Past work experience and the kinds of responsibilities the claimant had when he or she was working may show that he or she has intellectual abilities, although the claimant may have little formal education. A claimant's daily

activities, hobbies, or the results of testing may also show that the claimant has significant intellectual ability that can be used to work.

(b) *How the Board evaluates the claimant's education.* The importance of the claimant's educational background may depend upon how much time has passed between the completion of the claimant's formal education and the beginning of the claimant's physical or mental impairment(s) and what the claimant has done with his or her education in a work or other setting. Formal education completed many years before the claimant's impairment(s) began, or unused skills and knowledge that were a part of the claimant's formal education, may no longer be useful or meaningful in terms of ability to work. Therefore, the numerical grade level that the claimant completed in school may not represent his or her actual educational abilities. These educational abilities may be higher or lower than the numerical grade level that the claimant completed. However, if there is no other evidence to contradict it, the Board uses the claimant's numerical grade level to determine the claimant's educational abilities. The term ''education'' also includes how well the claimant is able to communicate in English since this ability is often acquired or improved by education. In evaluating the claimant's educational level, the Board uses the following categories:

(1) *Illiteracy.* Illiteracy means the inability to read or write. The Board will consider the claimant illiterate if he or she cannot read or write a simple message such as instructions or inventory lists even though the claimant can sign his or her name. Generally, the illiterate claimant has had little or no formal schooling.

(2) *Marginal education.* Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. Generally, this means a 6th grade or less level of education.

(3) *Limited education.* Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex duties needed in semi-skilled or skilled jobs. Generally, a limited education is a 7th grade through 11th grade level of education.

(4) *High school education and above.* High school and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. The claimant with this level of education is generally considered able to do semi-skilled through skilled work.

(5) *Inability to communicate in English.* Since the ability to speak, read, and understand English is generally learned or increased at school, the Board may consider this an educational factor. Because English is the dominant language of the country, it may be difficult for the claimant who does not speak and understand English to do a job, regardless of the amount of education he or she may have in another language. The claimant's ability to speak, read and understand English will be considered when the Board evaluates what work, if any, he or she can do.

(6) *Information about the claimant's education.* The Board will ask the claimant how long he or she attended school and whether he or she can speak, understand, read and write in English, and do at least simple calculations in arithmetic. The Board will also consider information about how much formal or informal education the claimant received from his or her previous work, community projects, hobbies and any other activities which might help him or her to work.

§ 220.130 Work experience as a vocational factor.

(a) *General—Work experience* means skills and abilities the claimant has acquired through work he or she has done which show the type of work he or she may be expected to do. Work the claimant has already been able to do shows the kind of work that he or she may be expected to do. The Board considers that the claimant's work experience is relevant and applies when it was done within the last 15 years, lasted long enough for him or her to learn to do it, and was substantial gainful activity. This work experience is called ''past relevant work.'' The

Board does not usually consider that work the claimant did 15 years or more before the time the Board is deciding whether he or she is disabled (or when the disability insured status requirement was last met, if earlier) applies. A gradual change occurs in most jobs so that after 15 years, it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If the claimant has no work experience or worked only ''off-and-on'' or for brief periods of time during the 15-year period, the Board generally considers that these do not apply. If the claimant has acquired skills through his or her past work, the Board considers the claimant to have these work skills unless he or she cannot use them in other skilled or semi-skilled work that he or she can do. If the claimant cannot use his or her skills in other skilled or semi-skilled work, the Board will consider his or her work background the same as unskilled. However, even if the claimant has no work experience, the Board may consider that the claimant is able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about the claimant's work.* (1) Sometimes the Board will need information about the claimant's past work to make a disability determination. The Board may request work information from—

(i) The claimant; and

(ii) The claimant's employer or other person who knows about the claimant's work (member of family or co-worker) with the claimant's permission.

(2) The Board will ask for the following information about all the jobs the claimant has had in the last 15 years:

(i) The dates the claimant worked.

(ii) All the duites the claimant did.

(iii) Any tools, machinery, and equipment the claimant used.

(iv) The amount of walking, standing, sitting, lifting and carrying the claimant did during the work day, as well as any other physical and mental duties of the job.

(3) If all the claimant's work in the past 15 years has been arduous and unskilled, and the claimant has very little education, the Board will ask the claimant to tell about all of his or her work from the time he or she first began working. (See § 220.45(b).)

§ 220.131 Work which exists in the national economy.

(a) *General.* The Board considers that work exists in the national economy when it exists in significant numbers either in the region where the claimant lives or in several other regions of the country. It does not matter whether—

(1) Work exits in the immediate area in which the claimant lives,

(2) A specific job vacancy exists for the claimant; or

(3) The claimant would be hired if the claimant applied for work.

(b) *How the Board determines the existence of work.* Work exists in the national economy when there are a significant number of jobs (in one or more occupations) having requirements which the claimant is able to meet with his or her physical or mental ability and vocational qualifications. Isolated jobs that exist in very limited numbers in relatively few locations outside the region where the claimant lives are not considered ''work which exists in the national economy.'' The Board will not deny the claimant a disability annuity on the basis of the existence of these kinds of jobs. The Board will determine that the claimant is disabled if the work he or she can do does not exist in the national economy. If the work the claimant can do does exist in the national economy, the Board will determine that the claimant is not disabled.

(c) *Inability to obtain work.* The Board will determine that the claimant is not disabled if he or she has the residual functional capacity and vocational abilities to do work which exists in the national economy but the claimant remains unemployed because of—

(1) His or her inability to get work;

(2) Lack of work in his or her local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which the claimant has worked;

(5) Cyclical economic conditions;

(6) No job openings for the claimant;

(7) The claimant not actually being hired to do work he or she could otherwise do; or

(8) The claimant not wishing to do a particular type of work.

(d) *Administrative notice of job data.* The following sources are used when the Board determines that unskilled, sedentary, light and medium jobs exist in the national economy:

(1) *Dictionary of Occupational Titles*, published by the Department of Labor.

(2) *County Business Patterns*, published by the Bureau of the Census.

(3) *Census Reports*, also published by the Bureau of the Census.

(4) *Occupational Analyses*, prepared for the Social Security Administration by various State employment agencies.

(5) *Occupational Outlook Handbook*, published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether the claimant is disabled is whether his or her work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, the Board may use the services of a vocational expert or other specialist. The Board will decide whether to use a vocational expert or other specialist.

§ 220.132 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, jobs are classified as ''sedentary'', ''light'', ''medium'', ''heavy'', and ''very heavy.'' These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. In making disability determinations the Board uses the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and the other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, the claimant must have the ability to do substantially all of these activities. If the claimant can do light work, the Board determines that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexerity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If the claimant can do medium work, the Board determines that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If the claimant can do heavy work, the Board determines that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If the claimant can do very heavy work, the Board determines that he or she can also do heavy, medium, light and sedentary work.

§ 220.133 Skill requirements.

(a) *General.* To evaluate skills and to help determine the existence in the national economy of work the claimant is able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, the Board uses materials published by the Department of Labor.

(b) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time (30 days). The job may or may not require

considerable strength. A job is considered unskilled if the claimant can usually learn to do the job in 30 days, and little job training and judgment are needed. The claimant does not gain work skills by doing unskilled jobs. For example, jobs are considered unskilled if primary work duties are—

(1) Handling;

(2) Feeding;

(3) Offbearing (placing or removing materials from machines which are automatic or operated by others); or

(4) Machine tending.

(c) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more complex work duties. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hand or feet must be moved quickly to do repetitive tasks. Semi-skilled jobs may require—

(1) Alertness and close attention to watching machine processes;

(2) Inspecting, testing, or otherwise looking for irregularities;

(3) Tending or guarding equipment, property, materials, or persons against loss, damage, or injury; or

(4) Other types of activities which are similarly less complex than skilled work but more complex than unskilled work.

(d) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled jobs may require—

(1) Laying out work;

(2) Estimating quality;

(3) Determining suitability and needed quantities of materials;

(4) Making precise measurements;

(5) Reading blueprints or other specifications;

(6) Making necessary computations or mechanical adjustments to control or regulate work; or

(7) Dealing with people, facts, figures or abstract ideas at a high level of complexity.

(e) *Skills that can be used in other work (transferability)*—(1) *What the Board means by transferable skills.* The Board considers the claimant to have skills that can be used in other jobs, when the skilled or semi-skilled work activities the claimant did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How the Board determines skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, they are considered not transferable.

§ 220.134 Medical-vocational guidelines in appendix 2 of this part.

(a) The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 of this part provides rules using this data reflecting major functional and vocational patterns.

(b) The Board applies that rules in appendix 2 of this part in cases where a claimant is not doing substantial gainful activity and is prevented by a severe impairment(s) from doing vocationally relevant past work.

(c) The rules in appendix 2 of this part do not cover all possible variations of factors. The Board does not apply these rules if one of the findings of fact about the claimant's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these

instances, the Board gives full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, the Board uses that rule to decide whether that claimant is disabled.

§ 220.135 Exertional and nonexertional limitations.

(a) *General.* The claimant's impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit the claimant's ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect the claimant's ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary, light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 220.132 and 220.134 of this part explain how the Board uses the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect the claimant's ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. Sections 220.100(b)(5) and 220.180(h) of this part explain that if the claimant can no longer do the claimant's past relevant work because of a severe medically determinable impairment(s), the Board must determine whether the claimant's impairment(s), when considered along with the claimant's age, education, and work experience, prevents the claimant from doing any other work which exists in the national economy in order to decide whether the claimant is disabled or continues to be disabled. Paragraphs (b), (c), and (d) of this section explain how the Board applies the medical-vocational guidelines in Appendix 2 of this part in making this determination, depending on whether the limitations or restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect only the claimant's ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), the Board considers that the claimant has only exertional limitations. When the claimant's impairment(s) and related symptoms only impose exertional limitations and the claimant's specific vocational profile is listed in a rule contained in Appendix 2 of this part, the Board will directly apply that rule to decide whether the claimant is disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect only the claimant's ability to meet the demands of jobs other than the strength demands, the Board considers that the claimant has only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) Difficulty functioning because the claimant is nervous, anxious, or depressed;

(ii) Difficulty maintaining attention or concentration;

(iii) Difficulty understanding or remembering detailed instructions;

(iv) Difficulty in seeing or hearing;

(v) Difficulty tolerating some physical feature(s) of certain work settings, *e.g.,* the claimant cannot tolerate dust or fumes; or

(vi) Difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If the claimant's impairment(s) and related symptoms, such as pain, only affect the claimant's ability to

perform the nonexertional aspects of work-related activities, the rules in Appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in Appendix 2 of this part.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by the claimant's impairment(s) and related symptoms, such as pain, affect the claimant's ability to meet both the strength and demands of jobs other than the strength demands, the Board considers that the claimant has a combination of exertional and nonexertional limitations or restrictions. If the claimant's impairment(s) and related symptoms, such as pain, affect the claimant's ability to meet both the strength and demands of jobs other than the strength demands, the Board will not directly apply the rules in Appendix 2 unless there is a rule that directs a conclusion that the claimant is disabled based upon the claimant's strength limitations; otherwise the rules provide a framework to guide the Board's decision.

[68 FR 60294, Oct. 22, 2003]

Subpart L—Substantial Gainful Activity

§ 220.140 General.

The work that a claimant has done during any period in which the claimant believes he or she is disabled may show that the claimant is able to do work at the substantial gainful activity level. If the claimant is able to engage in substantial gainful activity, the Board will find that the claimant is not disabled for any regular employment under the Railroad Retirement Act. Even if the work the claimant has done was not substantial gainful activity, it may show that the claimant is able to do more work than he or she actually did. The Board will consider all of the medical and vocational evidence in the claimant's file to decide whether or not the claimant has the ability to engage in substantial gainful activity.

§ 220.141 Substantial gainful activity, defined.

Substantial gainful activity is work activity that is both substantial and gainful.

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. The claimant's work may be substantial even if it is done on a part-time basis or if the claimant does less, gets paid less, or has less responsibility than when the claimant worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that the claimant does for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, the Board does not consider activities like taking care of one's self, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 220.142 General information about work activity.

(a) *The nature of the claimant's work.* If the claimant's duties require use of the claimant's experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that the claimant has the ability to work at the substantial gainful activity level.

(b) *How well the claimant performs.* The Board considers how well the claimant does his or her work when the Board determines whether or not the claimant is doing substantial gainful activity. If the claimant does his or her work satisfactorily, this may show that the claimant is working at the substantial gainful activity level. If the claimant is unable, because of his or her impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that the claimant is not working at the substantial gainful activity level. If the claimant is doing work that involves minimal duties that make little or no demands on the claimant and that are of little or no use to the claimant's

railroad or non-railroad employer, or to the operation of a business if the claimant is self-employed, this does not show that the claimant is working at the substantial gainful activity level.

(c) *If the claimant's work is done under special conditions.* Even though the work the claimant is doing takes into account his or her impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that the claimant has the necessary skills and ability to work at the substantial gainful activity level.

(d) *If the claimant is self-employed.* Supervisory, managerial, advisory or other significant personal services that the claimant performs as a self-employed person may show that the claimant is able to do substantial gainful activity.

(e) *Time spent in work.* While the time the claimant spends in work is important, the Board will not decide whether or not the claimant is doing substantial gainful activity only on that basis. The Board will still evaluate the work to decide whether it is substantial and gainful regardless of whether the claimant spends more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

§ 220.143 Evaluation guides for an employed claimant.

(a) *General.* The Board uses several guides to decide whether the work the claimant has done shows that he or she is able to do substantial gainful activity.

(1) *The claimant's earnings may show the claimant has done substantial gainful activity.* The amount of the claimant's earnings from work the claimant has done may show that he or she has engaged in substantial gainful activity. Generally, if the claimant worked for substantial earnings, this will show that he or she is able to do substantial gainful activity. On the other hand, the fact that the claimant's earnings are not substantial will not necessarily show that the claimant is not able to do substantial gainful activity. The Board will generally consider work that the claimant is forced to stop after a short time because of his or her impairment(s) as an unsuccessful work attempt and the claimant's earnings from that work will not show that the claimant is able to do substantial gainful activity.

(2) *The Board considers only the amount the claimant earns.* The Board does not consider any income not directly related to the claimant's productivity when the Board decides whether the claimant has done substantial gainful activity. If the claimant's earnings are subsidized, the amount of the subsidy is not counted when the Board determines whether or not the claimant's work is substantial gainful activity. Thus, where work is done under special conditions, the Board only considers the part of the claimant's pay which the claimant actually ''earns.'' For example, where a handicapped person does simple tasks under close and continuous supervision, the Board would not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. A railroad or non-railroad employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If the claimant's work is subsidized and the claimant's railroad and non-railroad employer does not set the amount of the subsidy or does not adequately explain how the subsidy was figured, the Board will investigate to see how much the claimant's work is worth.

(3) *If the claimant is working in a sheltered or special environment.* If the claimant is working in a sheltered workshop, the claimant may or may not be earning the amounts he or she is being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that the claimant is not earning all he or she is being paid. Since persons in military service being treated for a severe impairment usually continue to receive full pay, the Board evaluates work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of

the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines*—(1) *General.* If the claimant is employed, the Board first considers the criteria in paragraph (a) of this section and § 220.145, and then the guides in paragraphs (b)(2), (3), (4), (5), and (6) of this section.

(2) *Earnings that will ordinarily show that the claimant has engaged in substantial gainful activity.* The Board will consider that the earnings from the employed claimant's work activities show that the claimant has engaged in substantial gainful activity if—

For months	Monthly earnings averaged more than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
In January 1990–June 1999	500
After June 1999	700

(3) *Earnings that will ordinarily show that the claimant has not engaged in substantial gainful activity.* The Board will generally consider that the earnings from the employed claimant's work will show that the claimant has not engaged in substantial gainful activity if—

For months	Monthly earnings averaged less than
In calendar years before 1976	$130
In calendar year 1976	150
In calendar year 1977	160
In calendar year 1978	170
In calendar year 1979	180
In calendar years 1980–1989	190
After December 1989	300

(4) *If the claimant works in a sheltered workshop.* If the claimant is working in a sheltered workshop or a comparable facility especially set up for severely impaired persons, the claimant's earnings and activities will ordinarily establish that the claimant has not done substantial gainful activity if—

For months	Average monthly earnings are not greater than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
In January 1990–June 1999	500
After June 1999	700

(5) *If there is evidence showing that the claimant may have done substantial gainful activity.* If there is evidence showing that the claimant may have done substantial gainful activity, the Board will apply the criteria in paragraph (b)(6) of this section regarding comparability and value of services.

(6) *Earnings that are not high or low enough to show whether the claimant engaged in substantial gainful activity.* If the claimant's earnings, on the average, are between the amounts shown in paragraph (b)(2) and (3) of this section, the Board will generally consider other information in addition to the claimant's earnings, such as whether—

(i) The claimant's work is comparable to that of unimpaired persons in the claimant's community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work; or

(ii) The claimant's work, although significantly less than that done by unimpaired persons, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in the claimant's community.

[56 FR 12980, Mar 28, 1991, as amended at 64 FR 62976, Nov. 18, 1999]

§ 220.144 Evaluation guides for a self-employed claimant.

(a) *If the claimant is a self-employed claimant.* The Board will consider the claimant's activities and their value to the claimant's business to decide whether the claimant has engaged in substantial gainful activity if the claimant is self-employed. The Board will not consider the claimant's income alone since the amount of income the claimant actually receives may depend upon a number of different factors

like capital investment, profit sharing agreements, etc. The Board will generally consider work that the claimant is forced to stop after a short time because of his or her impairment(s) as an unsuccessful work attempt and the claimant's income from that work will not show that the claimant is able to do substantial gainful activity. The Board will evaluate the claimant's work activity on the value to the business of the claimant's services regardless of whether the claimant receives an immediate income for his or her services. The Board considers that the claimant has engaged in substantial gainful activity if—

(1) The claimant's work activity, in terms of factors such as hours, skills, energy output, efficency, duties, and responsibilities, is comparable to that of unimpaired persons in the claimant's community who are in the same or similar businesses as their means of livelihood;

(2) The claimant's work activity, although not comparable to that of unimpaired persons, is clearly worth the amount shown in § 220.143(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employed person to do the work the claimant is doing; or

(3) The claimant renders services that are significant to the operation of the business and receives a substantial income from the business.

(b) *What the Board means by significant services*—(1) *Claimants who are not farm landlords.* If the claimant is not a farm landlord and the claimant operates a business entirely by himself or herself, any services that the claimant renders are significant to the business. If the claimant's business involves the services of more than one person, the Board will consider the claimant to be rendering significant services if he or she contributes more than half the total time required for the management of the business or he or she renders management services for more than 45 hours a month regardless of the total management time required by the business.

(2) *Claimants who are farm landlords*—(i) *General.* If the claimant is a farm landlord, that is, the claimant rents farm land to another, the Board will consider the claimant to be rendering significant services if the claimant materially participates in the production or the management of the production of the things raised on the rented farm. If the claimant was given social security earnings credits because he or she materially participated in the activities of the farm and he or she continues these same activities, the Board will consider the claimant to be rendering significant services.

(ii) *Material participation.* (A) The claimant will have established that he or she is materially participating if he or she—

(*1*) Furnishes a large portion of the machinery, tools, and livestock used in the production of the things raised on the rented farm; or

(*2*) Furnishes or advances monies or assumes financial responsibility for a substantial part of the expense involved in the production of the things raised on the rented farm.

(B) The claimant will have presented strong evidence that he or she is materially participating if he or she periodically—

(*1*) Advise or consults with the other person who under the rental agreement produces the things raised on the rented farm; and

(*2*) Inspects the production activities on the land.

(iii) *Production.* The term ''production'' refers to the physical work performed and the expenses incurred in producing the things raised on the farm. It includes activities like the actual work of planting, cultivating, and harvesting of crops, and the furnishing of machinery, implements, seed, and livestock.

(iv) *Management of the production.* The term ''management of the production'' refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray or harvest. It includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(c) *What the Board means by substantial income.* After the claimant's normal business expenses are deducted from the claimant's gross income to determine net income, the Board will deduct the reasonable value of any unpaid help, any soil bank payments that were included as farm income, and impairment-related work expenses described in § 220.145 that have not been deducted in determining the claimant's net earnings from self-employment. The Board will consider the resulting amount of income from the business to be substantial if—

(1) It averages more than the amounts described in § 220.143(b)(2); or

(2) It averages less than the amounts described in § 220.143(b)(2) but the livelihood which the claimant gets from the business is either comparable to what it was before the claimant became severely impaired or is comparable to that of unimpaired self-employed persons in the claimant's community who are in the same or similar businesses as their means of livelihood.

§ 220.145 Impairment-related work expenses.

(a) *General.* When the Board figures the claimant's earnings in deciding if the claimant has done substantial gainful activity, the Board will subtract the reasonable costs to the claimant of certain items and services which, because of his or her impairment(s), the claimant needs and uses to enable him or her to work. The costs are deductible even though the claimant also needs or uses the items and services to carry out daily living functions unrelated to his or her work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses the Board will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains the Board's verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* The Board will deduct impairment-related work expenses if—

(1) The claimant is otherwise disabled as defined in § 220.26;

(2) The severity of the claimant's impairment(s) requires the claimant to purchase (or rent) certain items and services in order to work;

(3) The claimant pays the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that the claimant has been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if the claimant purchases crutches for $80 but the claimant was, could be, or will be reimbursed $64 by some agency, plan, or program, the Board will deduct only $16;

(4) The claimant pays for the item or service in a month he or she is working (in accordance with paragraph (d) of this section); and

(5) The claimant's payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of the claimant's impairment(s) the claimant needs assistance in traveling to and from work, or while at work the claimant needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments the claimant makes for those services may be deducted.

(ii) If because of the claimant's impairment(s) the claimant needs assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments the claimant makes for those services may be deducted.

(iii)(A) The Board will deduct payments the claimant makes to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) The Board considers a family member to be anyone who is related to the claimant by blood, marriage or adoption, whether or not that person lives with the claimant.

(iv) If only part of the claimant's payment to a person is for services that come under the provisions of paragraph (c)(1) of this section, the Board will only deduct that part of the payment which is attributable to those services. For example, an attendant gets the claimant ready for work and helps the claimant in returning from work, which takes about 2 hours a day. The rest of the attendant's 8-hour day is spent cleaning the claimant's house and doing the claimant's laundry, etc. The Board would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payment for medical devices.* If the claimant's impairment(s) requires that the claimant utilize medical devices in order to work, the payments the claimant makes for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If the claimant's impairment(s) requires that the claimant utilize a prosthetic device in order to work, the payments the claimant makes for that device can be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment*—(i) *Work-related equipment.* If the claimant's impairment(s) requires that the claimant utilize special equipment in order to do his or her job, the payments the claimant makes for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If the claimant's impairment(s) requires that the claimant make modifications to his or her residence, the location of the claimant's place of work will determine if the cost of these modifications will be deducted. If the claimant is employed away from home, only the cost of changes made outside of the claimant's home to permit the claimant to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the claimant's home will not be deducted. If the claimant works at home, the costs of modifying the inside of the claimant's home in order to create a working space to accommodate the claimant's impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which the claimant works. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if the claimant is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Non-medical applicances and equipment.* Expenses for appliances and equipment which the claimant does not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is for the control of the claimant's disabling impairment(s), thus enabling the claimant to work. To be considered essential, the item must be of such a nature that if it were not available to the claimant there would be an immediate adverse impact on the claimant's ability to function in his or her work activity. In this situation, the expense is deductible whether the item is used

at home or in the working place. An example would be the need for an electric air cleaner by a person with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If an exercycle is prescribed and used as necessary treatment to enable the claimant to work, the Board will deduct payments the claimant makes toward its cost.

(5) *Payments for drugs and medical services.* (i) If the claimant must use drugs or medical services (including diagnostic procedures) to control his or her impairment(s), the payments the claimant makes for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of the claimant's impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anti-convulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental impairments; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal impairments; electroencephalograms and brain scans related to a disabling epileptic impairment; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) The Board will only deduct the costs of drugs or services that are directly related to the claimant's impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If the claimant is required to utilize items and services not specified in paragraphs (c)(1) through (5) of this section, but which are directly related to his or her impairment(s) and which the claimant needs to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a dog guide which the claimant needs to work, and transportation.

(ii) *Medical supplies and services not described above.* The Board will deduct payments the claimant makes for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. The Board will also deduct payments the claimant makes for physical therapy which the claimant requires because of his or her impairment(s) and which the claimant needs in order to work.

(iii) *Payments for transportation costs.* The Board will deduct transportation costs in these situations:

(A) The claimant's impairment(s) requires that in order to get to work the claimant needs a vehicle that has structural or operational modifications. The modifications must be critical to the claimant's operation or use of the vehicle and directly related to the claimant's impairment(s). The Board will deduct the cost of the modifications, but not the cost of the vehicle. The Board will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) The claimant's impairment(s) requires the claimant to use driver assistance, taxicabs or other hired vehicles in order to work. The Board will deduct amounts paid to the driver and, if the claimant's own vehicle is used, the Board will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) The claimant's impairment(s) prevents the claimant from taking available public transportation to and from work and the claimant must drive his or her (unmodified) vehicle to work. If the Board can verify through the claimant's physician or other sources that the need to drive is caused by the claimant's impairment(s) (and

not due to the unavailability of public transportation), the Board will deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that the claimant utilizes qualifies as a deductible item as described in paragraphs (c)(2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii)(A) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted*—(1) *Effective date.* To be deductible, an expense must be incurred after November 30, 1980. An expense may be considered incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* A payment the claimant makes for services may be deducted if the services are received while the claimant is working and the payment is made in a month the claimant is working. The Board considers the claimant to be working even though he or she must leave work temporarily to receive the services.

(3) *Payments for items.* A payment the claimant makes toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month claimant is working. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated*—(1) *Recurring expenses.* The claimant may pay for services on a regular periodic basis, or the claimant may purchase an item on credit and pay for it in regular periodic installments or the claimant may rent an item. If so, each payment the claimant makes for the services and each payment the claimant makes toward the purchase or rental (including interest) is deductible in the month it is made.

Example: B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5,520 divided by 48) for each month of work during the 48 months.

(2) *Non-recurring expenses.* Part or all of the claimant's expenses may not be recurring. For example, the claimant may make a one-time payment in full for an item or service or make a downpayment. If the claimant is working when he or she makes the payment, the Board will either deduct the entire amount in the month the claimant pays it or allocate the amount over a 12-consecutive-month period beginning with the month of payment, whichever the claimant selects.

Example: A begins working in October 1981 and earns $525 a month. In the same month, he purchases and pays for a deductible item at a cost of $250. In this situation the Board could allow a $250 deduction for October 1981, reducing A's earnings below the substantial gainful activity level for that month.

If A's earnings had been $15 above the substantial gainful activity earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction would reduce A's earnings below the substantial gainful activity level for 12 months.

(3) *Allocating downpayments.* If the claimant makes a downpayment, the Board will, if the claimant chooses, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations the Board will determine the total payment that the claimant will make over a 12-consecutive-month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if the claimant's regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200

down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the downpayment allocated. In this situation the Board would allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work during the remaining installment period.

Explanation:	
Downpayment in October 1981	$1,200
Monthly payments: November 1981 through September 1982	1,265
	12/$2,465=205.42

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation, the Board would allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:	
Downpayment in July 1981	$1,450
Monthly payments: September 1981 through June 1982	1,250
	12/$2,700=$225

(4) *Payments made in anticipation of work.* A payment made toward the cost of a deductible item that the claimant made in any of the 11 months preceding the month he or she started working will be taken into account in determining the claimant's impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month the claiment started working, the payment will be allocated over the 12-consecutive-month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that the claimant made for a particular item during the 11 months preceding the month he or she started working will be totalled and considered to have been made in the month of the claimant's first payment for that item within this 11-month period. The sum of these payments will be allocated over the 12-consecutive-month period beginning with the month of the claimant's first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work. The Board will deduct either this entire amount in the first month of work or allocate it over a 12-consecutive-month period, beginning with the first month of work, whichever the claimant selects. In the above examples, the claimant would have the choice of having the entire $450 deducted in the first month of work or having $37.50 a month ($450 divided by 12) deducted for each month that he or she works over a 12-consecutive-month period, beginning with the first month of work. To be deductible, the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, non-medical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for the purpose of this paragraph.

(f) *Limits on deductions.* (1) The Board will deduct the actual amounts the claimant pays towards his or her impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment,

prosthetic devices, medical services, and similar medically-related items and services, the Board will apply the prevailing charges under Medicare (Part B of the title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, the Board will consider the amount that the claimant pays to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount the claimant actually pays is more than the prevailing charge for the same item under the Medicare guidelines, the Board will deduct from the claimant's earnings the amount the claimant paid to the extent he or she establishes that the amount is consistent with the standard or normal charge for the same or similar item or service in his or her community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, the Board will consider the amount the claimant pays to be reasonable if it does not exceed the standard or normal charge for the same or similar item or service in the claimant's community.

(2) Impairment-related work expenses are not deducted in computing the claimant's earnings for purposes of determining whether the claimant's work was ''services'' as described in § 220.170.

(3) The decision as to whether the claimant performed substantial gainful activity in a case involving impairment-related work expenses for items or services necessary for the claimant to work generally will be based upon the claimant's ''earnings'' and not on the value of ''services'' the claimant rendered. (See §§ 220.143 (b)(6)(i) and (ii), and 220.144(a)). This is not necessarily so, however, if the claimant is in a position to control or manipulate his or her earnings.

(4) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that the claimant has been, could be, or will be reimbursed for payments he or she made. (See paragraph (b)(3) of this section.)

(5) The provisions described in the foregoing paragraphs in this section are effective with respect to expenses incurred on or after December 1, 1980, although expenses incurred after November 1980, as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980, the Board will deduct impairment-related work expenses from the claimant's earnings only to the extent they exceeded the normal work-related expenses the claimant would have had if the claimant did not have his or her impairment(s). The Board will not deduct expenses, however, for those things with the claimant needed even when he or she was not working.

(g) *Verification.* The Board will verify the claimant's need for items or services for which deductions are claimed, and the amount of the charges for those items or services. The claimant will also be asked to provide proof that he or she paid for the items or services.

Subpart M—Disability Annuity Earnings Restrictions

§ 220.160 How work for a railroad employer affects a disability annuity.

A disability annuity is not payable and the annuity must be returned for any month in which the disabled annuitant works for an employer as defined in part 202 of this chapter.

§ 220.161 How work affects an employee disability annuity.

In addition to the condition in § 220.160, the employee's disability annuity is not payable and the employee must return the annuity payment for any month in which the employee earns more than $400 (after deduction of impairment-related work expenses) in employment or self-employment of any kind. Any annuity amounts withheld because the annuitant earned over $400 in a month may be paid after the end of the year, as shown in § 220.164. The $400 monthly limit no longer applies when the employee attains retirement age and the disability annuity is converted to a full age annuity. See

§ 220.145 for the definition of impairment-related work expenses.

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§ 220.162 Earnings report.

(a) *General.* Any annuitant receiving an annuity based on disability must report to the Board any work and earnings as described in § 220.160 and § 220.161. The report may be a written or oral statement by the annuitant, or a person acting for the annuitant, made or sent to a representative of the Board. The report should include the name and address of the railroad or non-railroad employer, a description of the work and the amount of gross wages (before deductions) or the net income from self-employment (earnings after deducting business expenses).

(b) *Employee reports.* In addition to the requirement described in (a), a report of earnings over $400 a month must be made before the employee accepts a disability annuity (the annuity payment is issued and not returned) for the second month after the first month in which earnings are over $400. Along with the report, the employee must return the annuity payment for any month in which he or she earns over $400.

§ 220.163 Employee penalty deductions.

If the employee earns over $400 in a month and does not report it within the time limit shown in § 220.162(b), a penalty is imposed. The penalty deduction for the first failure to report equals the annuity amount for the first month in which the employee earned over $400. The deduction for a second or later failure to report equals the annuity amount for each month in which the employee earned over $400 and failed to report it on time.

§ 220.164 Employee end-of-year adjustment.

(a) *General.* After the end of a year, the employee whose annuity was withheld for earnings over $400 in a month receives a form on which to report his or her earnings for the year.

(b) *Earnings are less than $5000.* If the employee's yearly earnings are less than $5000, all annuity payments and penalties withheld during the year because of earnings over $4800 are paid.

(c) *Earnings are $5000 or more.* (1) If the employee's yearly earnings are $5000 or more, the annuity payments are adjusted so that the employee does not have more than one regular deduction for every $400 of earnings over $4800. The last $200 or more of earnings over $4800 is treated as if it were $400. If the annuity rate changes during the year, any annuities due at the end of the year are paid first for months in which the annuity rate is higher. Penalty deductions may also apply as described in paragraph (c)(2) of this section.

(2) If the employee's yearly earnings are $5000 or more and the employee failed to report monthly earnings over $400 within the time limit described in § 220.162(b), penalty deductions will also apply. If it is the employee's first failure to report, the penalty deduction is equal to one month's annuity. If it is the employee's second or later failure to report, the penalty deduction equals the annuity amount for each month in which the employee earned over $400 and failed to report it on time.

(d) This section is illustrated by the following examples:

Example 1: Employee is awarded a disability annuity based upon his inability to engage in his regular railroad occupation effective January 1, 1989. During that year, he works April through October, for which he receives $785 per month. He does not report these earnings to the Board until January of the following year. The employee is considered to have earned $5600 (7×$785=$5495, which is rounded up to the nearest $400). He forfeits three months of annuities:

$$\left(\frac{\$5600-\$4800}{\$400}\right)=\begin{array}{c}\text{2 plus 1 month annuity}\\ \text{penalty for failure}\\ \text{to report}\end{array}$$

Example 2: The same employee in the following year also works April through October, for which he receives $785 per month. This time he reports the earnings on October 31. This year he forfeits 6 months of annuity payments, 2 due to earnings, computed as above, and 4 more due to penalty deductions for failure to report earnings over $400 for the months April through July. There are no penalty deductions with respect to the months August, September, and October, since the employee reported these earnings prior to accepting an annuity for the second

month after the month of earnings in excess of $400.

Subpart N—Trial Work Period and Reentitlement Period for Annuitants Disabled for Any Regular Employment

§ 220.170 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which the annuitant may test his or her ability to work and still be considered disabled. The trial work period begins and ends as described in paragraph (e) of this section. During this period, the annuitant may perform ''services'' (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. The Board will not consider those services as showing that the annuitant's disability has ended until the annuitant has performed services in at least 9 months. However, after the trial work period has ended, the Board will consider the work the annuitant did during the trial work period in determining whether the annuitant's disability has ended at any time after the trial work period.

(b) *What the Board means by services.* When used in this section, ''services'' means any activity, even though it is not substantial gainful activity, which is done by the annuitant in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. If the annuitant is employed, the Board will consider his or her work to be ''services'' if in any calendar year after 1989 the annuitant earns more than $200 a month ($75 a month is the figure for earnings in any calendar year before 1989). If the annuitant is self-employed, the Board will consider his or her activities ''services'' if in any calendar year after 1989 the annuitant's net earnings are more than $200 a month, ($75 a month is the figure for earnings in any calendar year before 1989), or the annuitant works more than 40 hours a month in the business in any calendar year after 1989 (15 hours a month is the figure for calendar years before 1990). The Board generally does not consider work to be ''services'' when it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house, or in self-care.

(c) *Limitations on the number of trial work periods.* The annuitant may have only one trial work period during each period in which he or she is disabled for any regular employment as defined in § 220.26.

(d) *Who is and is not entitled to a trial work period.* (1) Generally, the annuitant is entitled to a trial work period if he or she is entitled to an annuity based on disability.

(2) An annuitant is not entitled to a trial work period if he or she is in a second period of disability for which he or she did not have to complete a waiting period before qualifying for a disability annuity.

(e) *Payment of the disability annuity during the trial work period.* (1) The disability annuity of an employee, child, or widow(er) who is disabled for any regular employment will not be paid for any month in the trial work period in which the annuitant works for an employer covered by the Railroad Retirement Act (see § 220.160).

(2) The disability annuity of an employee who is disabled for any regular employment will not be paid for any month in this period in which the employee annuitant earns more than $400 in employment or self-employment (see § 220.161 and § 220.164).

(3) If the disability annuity for an employee, child, or widow(er) who is disabled for any regular employment is stopped because of work during the trial work period, and the disability annuitant discontinues that work before the end of the trial work period, the disability annuity may be started again without a new application and a new determination of disability.

(f) *When the trial work period begins and ends.* (1) The trial work period begins with whichever of the following calendar months is the later—

(i) The annuity beginning date;

(ii) The month after the end of the appropriate waiting period; or

(iii) The month the application for disability is filed.

(2) The trial work period ends with the close of whichever of the following calendar months is the earlier—

(i) The 9th month (whether or not the months have been consecutive) in

which the annuitant performed services; or

(ii) The month in which new evidence, other than evidence relating to any work the annuitant did during the trial work period, shows that the annuitant is not disabled, even though he or she has not worked a full 9 months. The Board may find that the annuitant's disability has ended at any time during the trial work period if the medical or other evidence shows that the annuitant is no longer disabled.

§ 220.171 The reentitlement period.

(a) *General.* (1) The reentitlement period is an additional period after the 9 months of trial work during which the annuitant may continue to test his or her ability to work if he or she has a disabling impairment(s).

(2) The disability annuity of an employee, child, or widow(er) who is disabled for any regular employment will not be paid for—

(i) Any month, after the 3rd month, in this period in which the annuitant does substantial gainful activity; or

(ii) Any month in this period in which the annuitant works for an employer covered by the Railroad Retirement Act (see § 220.160).

(3) The disability annuity of an employee who is disabled for any regular employment will not be paid for any month in this period in which the employee annuitant earns more than $400 in employment or self-employment (see § 220.161 and § 220.164).

(4) If the disability annuity of an employee, child or widow(er) who is disabled for any regular employment is stopped because of work during the trial work period or reentitlement period, and the disability annuitant discontinues that work before the end of either period, the disability annuity may be started again without a new application or a new determination of disability.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of nine months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which the annuitant's impairment(s) no longer exists or is not medically disabling; or

(2) The last day of the 36th month following the end of the annuitant's trial work period.

(c) *When the annuitant is not entitled to a reentitlement period.* The annuitant is not entitled to a reentitlement period if—

(1) He or she is not entitled to a trial work period; or

(2) His or her disability ended before the annuitant completed nine months of trial work in that period in which he or she was disabled.

Subpart O—Continuing or Stopping Disability Due to Substantial Gainful Activity or Medical Improvement

§ 220.175 Responsibility to notify the Board of events which affect disability.

If the annuitant is entitled to a disability annuity because he or she is disabled for any regular employment, the annuitant should promptly tell the Board if—

(a) His or her impairment(s) improves;

(b) He or she returns to work;

(c) He or she increases the amount of work; or

(d) His or her earnings increase.

§ 220.176 When disability continues or ends.

There is a statutory requirement that, if an annuitant is entitled to a disability annuity, the annuitant's continued entitlement to such an annuity must be reviewed periodically until the employee or child annuitant reaches full retirement age and the widow(er) annuitant reaches age 60. When the annuitant is entitled to a disability annuity as a disabled employee, disabled widow(er) or as a person disabled since childhood, there are a number of factors to be considered in deciding whether his or her disability continues. The Board must first consider whether the annuitant has worked and, by doing so, demonstrated the ability to engage in substantial gainful activity. If so, the disability will end. If the annuitant has not demonstrated the ability to engage in substantial gainful

activity, then the Board must determine if there has been any medical improvement in the annuitant's impairment(s) and, if so, whether this medical improvement is related to the annuitant's ability to work. If an impairment(s) has not medically improved, the Board must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to ability to work has not occurred and no exception applies, the disability will continue. Even the medical improvement related to ability to work has occurred or an exception applies (see § 220.179 for exceptions), in most cases the Board must also show that the annuitant is currently able to engage in substantial gainful activity before it can find that the annuitant is no longer disabled.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 39010, July 1, 2003]

§ 220.177 Terms and definitions.

There are several terms and definitions which are important to know in order to understand how the Board reviews whether a disability for any regular employment continues:

(a) *Medical improvement.* Medical improvement is any decrease in the medical severity of an impairment(s) which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on a comparison of prior and current medical evidence showing changes (improvement) in the symptoms, signs or laboratory findings associated with the impairment(s).

Example 1: The claimant was awarded a disability annuity due to a herniated disc. At the time of the Board's prior decision granting the claimant an annuity he had had a laminectomy.

Postoperatively, a myelogram still shows evidence of a persistant deficit in his lumbar spine. He had pain in his back, and pain and a burning sensation in his right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in his back and leg. When the Board reviewed the annuitant's claim to determine whether his disability should be continued, his treating physician reported that he had seen the annuitant regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. The annuitant's doctor further reported a moderately decreased range of motion in the annuitant's back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has not occurred because there has been no decrease in the severity of the annuitant's back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: The claimant was awarded a disability annuity due to rheumatoid arthritis. At the time, laboratory findings were positive for this impairment. The claimant's doctor reported persistent swelling and tenderness of the claimant's fingers and wrists and that he complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, the annuitant's impairment has responded favorably to therapy so that for the last year his fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairment as documented by the current symptoms and signs reported by his physician. Although the annuitant's impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. The Board would then determine if this medical improvement is related to the annuitant's ability to work.

(b) *Medical improvement not related to ability to do work.* Medical improvement is not related to the annuitant's ability to work if there has been a decrease in the severity of the impairment(s) (as defined in paragraph (a) of this section) present at the time of the most recent favorable medical decision, but no increase in that annuitant's functional capacity to do basic work activities as defined in paragraph (d) of this section. If there has been any medical improvement in an annuitant's impairment(s), but it is not related to the annuitant's ability to do work and none of the exceptions applies, the annuity will be continued.

Example: An annuitant was 65 inches tall and weighed 246 pounds at the time his disability was established. He had venous insufficiency and persistent edema in his legs. At the time, the annuitant's ability to do basic work activities was affected because he was able to sit for 6 hours, but was able to stand

or walk only occasionally. At the time of the Board's continuing disability review, the annuitant had undergone a vein stripping operation. He now weighed 220 pounds and had intermittent edema. He is still able to sit for 6 hours at a time and to stand or walk only occasionally although he reports less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by his weight loss and the improvement in his edema. This medical improvement is not related to his ability to work, however, because his functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

(c) *Medical improvement that is related to ability to do work.* Medical improvement is related to an annuitant's ability to work if there has been a decrease in the severity (as defined in paragraph (a) of this section) of the impairment(s) present at the time of the most recent favorable medical decision and an increase in the annuitant's functional capacity to do basic work activities as discussed in paragraph (d) of this section. A determination that medical improvement related to an annuitant's ability to do work has occurred does not, necessarily, mean that such annuitant's disability will be found to have ended unless it is also shown that the annuitant is currently able to engage in substantial gainful activity as discussed in paragraph (e) of this section.

Example 1: The annuitant has a back impairment and has had a laminectomy to relieve the nerve root impingement and weakness in his left leg. At the time of the Board's prior decision, basic work activities were affected because he was able to stand less than 6 hours, and sit no more than ½ hour at a time. The annuitant had a successful fusion operation on his back about 1 year before the Board's review of his entitlement. At the time of the Board's review, the weakness in his leg has decreased. The annuitant's functional capacity to perform basic work activities now is unimpaired because he now has no limitation on his ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of his impairment as demonstrated by the decreased weakness in his leg. This medical improvement is related to his ability to work because there has also been an increase in his functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on his ability to sit, walk, or stand. Whether or not his disability is found to have ended, however, will depend on the Board's determination as to whether he can currently engage in substantial gainful activity.

Example 2: The annuitant was injured in an automobile accident receiving a compound fracture to his right femur and a fractured pelvis. When he applied for disability annuity 10 months after the accident his doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. The annuitant's doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of the Board's review 6 months later, solid union had occurred and the annuitant had been returned to full weight-bearing for over a month. His doctor reported this and the fact that his prior fractures no longer placed any limitation on his ability to walk, stand, and lift, and, that in fact, he could return to full-time work if he so desired.

Medical improvement has occurred because there has been a decrease in the severity of the annuitant's impairments as shown by x-ray and clinical evidence of solid union and his return to full weight-bearing. This medical improvement is related to his ability to work because he no longer meets the same listed impairment in appendix 1 of this part (see § 220.178(c)(1)). Whether or not the annuitant's disability is found to have ended will depend on the Board's determination as to whether he can currently engage in substantial gainful activity.

(d) *Functional capacity to do basic work activities.* (1) Under the law, disability is defined, in part, as the inability to do any regular employment by reason of a physical or mental impairment(s). ''Regular employment'' is defined in this part as ''substantial gainful activity.'' In determining whether the annuitant is disabled under the law, the Board will measure, therefore, how and to what extent the annuitant's impairment(s) has affected his or her ability to do work. The Board does this by looking at how the annuitant's functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes in a work setting and dealing

with both supervisors and fellow workers. The annuitant who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment(s) will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time the annuitant could stand or walk and can result in damage to his or her eyes as well, so that the annuitant also had limited vision. What the annuitant can still do, despite his or her impairment(s), is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in § 220.120. Unless an impairment is so severe that it is deemed to prevent the annuitant from doing substantial gainful activity (i.e., the impairment(s) meets or equals the severity of a listed impairment in appendix 1 of this part), it is this residual functional capacity that is used to determine whether the annuitant can still do his or her past work or, in conjunction with his or her age, education and work experience, do any other work.

(2) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the annuitant can stand or walk for longer periods. When new evidence showing a change in medical findings establishes that both medical improvement has occurred and the annuitant's functional capacity to perform basic work activities, or residual functional capacity, has increased, the Board will find that medical improvement which is related to the annuitant's ability to do work has occurred. A residual functional capacity assessment is also used to determine whether an annuitant can engage in substantial gainful activity and, thus, whether he or she continues to be disabled (see paragraph (e) of this section).

(3) Many impairment-related factors must be considered in assessing an annuitant's functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(4) Studies have also shown that the longer the annuitant is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if the annuitant is age 50 or over and had been receiving a disability annuity for a considerable period of time, the Board will consider this factor along with his or her age in assessing the residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a longer period of disability will be considered. In some instances where available evidence does not resolve what the annuitant can or cannot do on a sustained basis, the Board may provide special work evaluations or other appropriate testing.

(e) *Ability to engage in substantial gainful activity.* In most instances, the Board must show that the annuitant is able to engage in substantial gainful activity before stopping his or her annuity. When doing this, the Board will consider all of the annuitant's current impairments not just that impairment(s) present at the time of the most recent favorable determination. If the Board cannot determine that the annuitant is still disabled based on medical considerations alone (as discussed in §§ 220.110 through 220.115), it will use

the new symptoms, signs and laboratory findings to make an objective assessment of functional capacity to do basic work activities (or residual functional capacity) and will consider vocational factors. See §§ 220.120 through 220.134.

(f) *Evidence and basis for the Board's decision.* The Board's decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that the annuitant had previously been determined to be disabled. The Board will consider all of the evidence the annuitant submits. An annuitant must give the Board reports from his or her physician, psychologist, or others who have treated or evaluated him or her, as well as any other evidence that will help the board determine if he or she is still disabled (see § 220.45). The annuitant must have a good reason for not giving the Board this information or the Board may find that his or her disability has ended (see § 220.178(b)(2)). If the Board asks the annuitant, he or she must contact his or her medical sources to help the Board get the medical reports. The Board will make every reasonable effort to help the annuitant in getting medical reports when he or she gives the Board permission to request them from his or her physician, psychologist, or other medical sources, Every reasonable effort means that the Board will make an initial request and, after 20 days, one follow-up request to the annuitant's medical source to obtain the medical evidence necessary to make a determination before the Board evaluates medical evidence obtained from another source on a consultative basis. The medical source will have 10 days from the follow-up to reply (unless experience indicates that a longer period is advisable in a particular case). In some instances the Board may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that an annuitant's disability has ended, the Board will develop a complete medical history covering at least the preceding 12 months (See § 220.45(b)). A consultative examination may be purchased when the Board needs additional evidence to determine whether or not an annuitant's disability continues. As a result, the Board may ask the annuitant, upon the Board request and reasonable notice, to undergo consultative examinations and tests to help the Board determine whether the annuitant is still disabled (see § 220.50). The Board will decide whether or not to purchase a consultative examination in accordance with the standards in §§ 220.53 through 220.54.

(g) *Point of comparison.* For purposes of determining whether medical improvement has occurred, the Board will compare the current medical severity of that impairment(s), which was present at the time of the most recent favorable medical decision that the annuitant was disabled or continued to be disabled, to the medical severity of that impairment(s) at that time. If medical improvement has occurred, the Board will compare the annuitant's current functional capacity to do basic work activities (i.e., his or her residual functional capacity) based on this previously existing impairment(s) with the annuitant's prior residual functional capacity in order to determine whether the medical improvement is related to his or her ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether the annuitant was disabled or continued to be disabled which became final.

§ 220.178 Determining medical improvement and its relationship to the annuitant's ability to do work.

(a) *General.* Paragraphs (a), (b), and (c) of § 220.177 discuss what is meant by medical improvement, medical improvement not related to the ability to work and medical improvement that is related to the ability to work. How the Board will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed in paragraphs (b) and (c) of this section.

(b) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, the Board then must determine if it is related to the annuitant's

ability to do work. In § 220.177(d) the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect the annuitant's residual functional capacity is explained. In determining whether medical improvement that has occurred is related to the annuitant's ability to do work, the Board will assess the annuitant's residual functional capacity (in accordance with § 220.177(d)) based on the current severity of the impairment(s) which was present at that annuitant's last favorable medical decision. The annuitant's new residual functional capacity will then be compared to the annuitant's residual functional capcity at the time of the Board's most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to the annuitant's ability to do work.

(c) *Additional factors and considerations.* The Board will also apply the following in its determinations of medical improvement and its relationship to the annuitant's ability to do work:

(1) *Previous impairment met or equaled listings.* If the Board's most recent favorable decision was based on the fact that the annuitant's impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of this part, an assessment of his or her residual functional capacity would not have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing, the Board will find that the medical improvement was related to the annuitant's ability to work. Appendix 1 of this part describes impairments which, if severe enough, affect the annuitant's ability to work. If the Listing level of severity is met or equaled, the annuitant is deemed, in the absence of evidence to the contrary, to be unable to engage in substantial gainful activity. If there has been medical improvement to the degree that the requirement of the listing is no longer met or equaled, then the medical improvement is related to the annuitant's ability to work. The Board must, of course, also establish that the annuitant can currenlty engage in gainful activity before finding that his or her disability has ended.

(2) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if an annuitant's functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(3) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of the annuitant's residual functional capacity (i.e., his or her impairment(s) did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of this part) but does not, either because this assessment is missing from the annuitant's file or because it was not done, the Board will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess the annuitant's functional capacity to do basic work activities. The Board will assign the maximum functional capacity consistent with an allowance.

Example: The annuitant was previously found to be disabled on the basis that while his impairment did not meet or equal a listing, it did prevent him from doing his past or any other work. The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of that decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of the annuitant's impairment will have to be compared with his residual functional capacity based on its prior severity in order to determine if the medical improvement is related to his ability to do work. In order to make this comparison, the Board will review the prior evidence and make an objective assessment of the annuitant's residual functional capacity

at the time of its most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(4) *Impairment subject to temporary remission.* In some cases the evidence shows that the annuitant's impairment(s) are subject to temporary remission. In assessing whether medical improvement has occurred in annuitants with this type of impairment(s), the Board will be careful to consider the longitudinal history of the impairment(s), including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairment(s) that is only temporary, i.e., less than 1 year, will not warrant a finding of medical improvement.

(5) *Prior file cannot be located.* If the prior file cannot be located, the Board will first determine whether the annuitant is able to now engage in substantial gainful activity based on all of his or her current impairments. (In this way, the Board will be able to determine that his or her disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If the annuitant cannot engage in substantial gainful activity currently, his or her disability will continue unless one of the second group of exceptions applies (see § 220.179(b)).

§ 220.179 Exceptions to medical improvement.

(a) *First group of exceptions to medical improvement.* The law provides for certain limited situations when the annuitant's disability can be found to have ended even though medical improvement has not occurred, if he or she can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that the annuitant is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the annuitant should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, the Board must also show that, taking all of the annuitant's current impairment(s) into account, not just those that existed at the time of the Board's most recent favorable medical decision, the annuitant is now able to engage in substantial gainful activity before his or her disability can be found to have ended. As part of the review process, the annuitant will be asked about any medical or vocational therapy that he or she has received or is receiving. Those answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that the annuitant is the beneficiary of advances in medical or vocational therapy or technology (related to his or her ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased the annuitant's ability to do basic work activities. The Board will apply this exception when substantial evidence shows that the annuitant has been the beneficiary of services which reflect these advances and they have favorably affected the severity of his or her impairment(s) or ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that the annuitant has undergone vocational therapy (related to his or her ability to work).* Vocational therapy (related to the annuitant's ability to work) may include, but is not limited to, additional education, training, or work experience that improves his or her ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. If, at the time of the Board's review the annuitant has not completed vocational therapy which could affect the continuance of his or her disability, the Board will review such annuitant's claim upon completion of the therapy.

Example 1: The annuitant was found to be disabled because the limitations imposed on him by his impairment(s) allowed him to only do work that was at a sedentary level of exertion. The annuitant's prior work experience was work that required a medium level of exertion with no acquired skills that could be transferred to sedentary work. His age, education, and past work experience at the time did not qualify him for work that was below this medium level of exertion. The annuitant enrolled in and completed a specialized training course which qualifies him for a job in data processing as a computer programmer in the period since he was awarded a disability annuity. On review of his claim, current evidence shows that there is no medical improvement and that he can still do only sedentary work. As the work of a computer programmer is sedentary in nature, he is now able to engage in substantial gainful activity when his new skills are considered.

Example 2: The annuitant was previously entitled to a disability annuity because the medical evidence and assessment of his residual functional capacity showed he could only do light work. His prior work was considered to be of a heavy exertional level with no acquired skills that could be transferred to light work. His age, education, and past work experience did not qualify him for work that was below the heavy level of exertion. The current evidence and residual functional capacity show there has been no medical improvement and that he can still do only light work. Since he was originally entitled to a disability annuity, his vocational rehabilitation agency enrolled him in and he successfully completed a trade school course so that he is now qualified to do small appliance repair. This work is light in nature, so when his new skills are considered, he is now able to engage in substantial gainful activity even though there has been no change in his residual functional capacity.

(3) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques the annuitant's impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that the annuitant's impairment(s) is not as severe as was determined at the time of the Board's most recent favorable medical decision, such evidence may serve as a basis for finding that the annuitant can engage in substantial gainful activity and is no longer disabled. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of the Board's most recent favorable medical decision.

(i) *How the Board will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evalutions will come to the Board's attention by several methods. In reviewing cases, the Board often becomes aware of new techniques when their results are presented as evidence. Such techniques and evalutions are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, the Board develops listings of new techniques and when they become generally available.

(ii) *How the annuitant will know which methods are new or improved techniques and when they become generally available.* The Board will let annuitants know which methods it considers to be new or improved techniques and when they become available. Some of the future changes in the Listing of Impairments in appendix 1 of this part will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved techniques will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of the annuitant's last favorable medical decision. Current evidence shows that the annuitant's impairment, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all his current impairments into account, the annuitant is now able to engage in substantial gainful activity, this exception would be used to find that he is no longer disabled even if medical improvement has not occurred.

(4) *Substantial evidence demonstrates that any prior disability decision was in*

error. The Board will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to an annuity based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of this part or a medical/vocational rule in appendix 2 of this part was misapplied).

Example 1: The annuitant was granted a disability annuity when it was determined that his epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. As history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of his seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether the annuitant was still considered to be disabled would be based on whether he could currently engage in substantial gainful activity.

Example 2: The annuitant's prior award of a disability annuity was based on vocational rule 201.14 in appendix 2 of this part. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at semiskilled level, and who can do only sedentary work. On review it is found that at the time of the prior determination the annuitant was actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of his claim and the prior decision is found to have been in error. Continuation of his disability would depend on a finding of his current inability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of the annuitant's impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: The annuitant was found disabled on the basis of chronic obstructive pulmonary disease. The severity of his impairment was documented primarily by pulmonary function testing results. The evidence showed that he could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that the annuitant's impairment does not limit his ability to perform basic work activities in any way. Error is found based on the fact that required material evidence, which was originally missing, now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence relating to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the disability would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: The annuitant was previously found entitled to a disability annuity on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that the annuitant has ''brittle'' diabetes for which he was taking insulin. The annuitant's urine was 3+ for sugar, and he alleged occasional hypoglycemic attacks caused by exertion. His doctor felt the diabetes was never really controlled because he was not following his diet or taking his medication regularly. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that the annuitant's impairment clearly does not equal the severity contemplated by the listings. Error cannot be found because it would represent a substitution of current judgement

for that of the prior adjudicator that the annuitant's impairment equaled a listing. The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision are met.

(5) *The annuitant is currently engaging in substantial gainful activity.* If the annuitant is currently engaging in substantial gainful activity, before the Board determines whether he or she is no longer disabled because of his or her work activity, the Board will consider whether he or she is entitled to a trial work period as set out in § 220.170. The Board will find that the annuitant's disability has ended in the month in which he or she demonstrated the ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether the annuitant continues to have a disabling impairment(s) for purposes of deciding his or her eligibility for a reentitlement period.

(b) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that the annuitant is no longer disabled. In these situations the decision will be made without a determination that the annuitant has medically improved or can engage in substantial gainful activity.

(1) *A prior determination was fraudulently obtained.* If the Board finds that any prior favorable determination was obtained by fraud, it may find that the annuitant is not disabled. In addition, the Board may reopen the claim.

(2) *Failure to cooperate with the Board.* If there is a question about whether the annuitant continues to be disabled and the Board requests that he or she submit medical or other evidence or go for a physical or mental examination by a certain date, the Board will find that the annuitant's disability has ended if he or she fails (without good cause) to do what is requested. The month in which the annuitant's disability ends will be the first month in which he or she failed to do what was requested.

(3) *Inability of the Board to locate the annuitant.* If there is question about whether the annuitant continues to be disabled and the Board is unable to find him or her to resolve the question, the Board will suspend annuity payments. If, after a suitable investigation, the Board is still unable to locate the annuitant, the Board will determine that the annuitant's disability has ended. The month such annuitant's disability ends will be the first month in which the question arose and the annuitant could not be found.

(4) *Failure of the annuitant to follow prescribed treatment which would be expected to restore the ability to engage in substantial gainful activity.* If treatment has been prescribed for the annuitant which would be expected to restore his or her ability to work, he or she must follow that treatment in order to be paid a disability annuity. If the annuitant is not following that treatment and he or she does not have good cause for failing to follow the treatment, the Board will find that his or her disability has ended. The month such annuitant's disability ends will be the first month in which he or she failed to follow the prescribed treatment.

§ 220.180 Determining continuation or cessation of disability.

Evaluation steps. To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop a disability annuity are made objectively, neutrally and are fully documented, the Board will follow specific steps in reviewing the question of whether an annuitant's disability continues. The Board's review may cease and the disability may be continued at any point if the Board determines that there is sufficient evidence to find that the annuitant is still unable to engage in substantial gainful activity. The steps are—

(a) Is the annuitant engaging in substantial gainful activity? If he or she is (and any applicable trial work period has been completed), the Board will find disability to have ended (see § 220.179(a)(5));

(b) If the annuitant is not engaging in substantial gainful activity, does he

or she have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of this part? If the annuitant's impairment(s) does meet or equal the level of severity of an impairment listed in appendix 1 of this part, his or her disability will be found to continue;

(c) If the annuitant's impairment(s) does not meet or equal the level of severity of an impairment listed in appendix 1 of this part, has there been medical improvement as defined in §220.177(a)? If there has been medical improvement as shown by a decrease in medical severity, see step (d). If there has been no decrease in medical severity, then there has been no medical improvement; (See step (e));

(d) If there has been medical improvement, the Board must determine whether it is related to the annuitant's ability to do work in accordance with paragraphs (a) through (d) of §220.177, (i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination). If medical improvement is not related to the annuitant's ability to do work, see step (e). If medical improvement is related to the annuitant's ability to do work, see step (f);

(e) If the Board found at step (c) that there has been no medical improvement or if it found at step (d) that the medical improvement is not related to the annuitant's ability to work, the Board considers whether any of the exceptions in §220.178 apply. If none of them apply, disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (f). If an exception from the second group of exceptions to medical improvement applies, disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process;

(f) If medical improvement is shown to be related to the annuitant's ability to do work or if one of the first group of exceptions to medical improvement applies, the Board will determine whether all of the annuitant's current impairments in combination are severe. This determination will consider all current impairments and the impact of the combination of those impairments on the ability to function. If the residual functional capacity assessment in step (d) above shows significant limitation of ability to do basic work activities, see step (g). When the evidence shows that all current impairments in combination do not significantly limit physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature, and the annuitant will no longer be consider to be disabled;

(g) If the annuitant's impairment(s) is severe, the Board will assess his or her current ability to engage in substantial gainful activity. That is, the Board will assess the annuitant's residual functional capacity based on all of his or her current impairments and consider whether he or she can still do work that was done in the past. If he or she can do such work, disability will be found to have ended; and

(h) If the annuitant is not able to do work he or she has done in the past, the Board will consider one final step. Given the residual functional capacity assessment and considering the annuitant's age, education and past work experience, can he or she do other work? If the annuitant can do other work, disability will be found to have ended. If he or she cannot do other work, disability will be found to continue.

§ 220.181 The month in which the Board will find that the annuitant is no longer disabled.

If the evidence shows that the annuitant is no longer disabled, the Board will find that his or her disability ended in the earliest of the following months—

(a) The month the Board mails the annuitant a notice saying that the Board finds that he or she is no longer disabled based on evidence showing:

(1) There has been medical improvement in the annuitant's impairments related to the ability to work and the annuitant has the capacity to engage in substantial gainful work under the rules set out in §§220.177 and 220.178; or

(2) There has been no medical improvement in the annuitant's impairments related to the ability to work but the annuitant has the capacity to engage in substantial gainful work and one of the exceptions to medical improvement set out in § 220.179(a)(1), (2), (3) or (4) applies.

(b) The month in which the annuitant demonstrated his or her ability to engage in substantial gainful activity (following completion of a trial work period);

(c) The month in which the annuitant actually does substantical gainful activity where such annuitant is not entitled to a trial work period;

(d) The month in which the annuitant returns to full-time work, with no significant medical restrictions and acknowledges that medical improvement has occurred, and the Board expected the annuitant's impairment(s) to improve;

(e) The first month in which the annuitant failed without good cause to do what the Board asked, when the rule set out in paragraph (b)(2) of § 220.179 applies;

(f) The first month in which the question of continuing disability arose and the Board could not locate the annuitant after a suitable investigation (see § 220.179(b)(3));

(g) The first month in which the annuitant failed without good cause to follow prescribed treatment, when the rule set out in paragraph (b)(4) of § 220.179 applies; or

(h) The first month the annuitant was told by his or her physician that he or she could return to work provided there is no substantial conflict between the physician's and the annuitant's statements regarding that annuitant's awareness of his or her capacity for work and the earlier date is supported by the medical evidence.

(i) The month the evidence shows that the annuitant is not longer disabled under the rules set out in §§ 220.177 through 220.180, and he or she was disabled only for a specified period of time in the past as discussed in § 220.21 or § 220.105;

§ 220.182 Before a disability annuity is stopped.

Before the Board stops a disability annuity, it will give the annuitant a chance to explain why it should not do so.

§ 220.183 Notice that the annuitant is not disabled.

(a) *General.* If the Board determines that the annuitant does not meet the disability requirements of the law, the disability annuity will generally stop. Except in the circumstance described in paragraph (d) of this section, the Board will give the annuitant advance written notice when the Board has determined that he or she is not now disabled.

(b) *What the advance written notice will tell the annuitant.* The advance written notice will provide—

(1) A summary of the information the Board has and an explanation of why the Board believes the annuitant is no longer disabled. If it is because of medical reasons, the notice will tell the annuitant what the medical information in his or her file shows. If it is because of the annuitant's work activity, the notice will tell the annuitant what information the Board has about the work he or she is doing or has done, and why this work shows that he or she is not disabled. If it is because of the annuitant's failure to give the Board information the Board needs or failure to do what the Board asks, the notice will tell the annuitant what information the Board needs and why, or what the annuitant has to do and why;

(2) The date the disability annuity will stop;

(3) An opportunity for the annuitant to submit evidence within a specified period to support continuance of disability before the decision becomes final; and

(4) An explanation of the annuitant's rights to reconsideration and appeal after the decision becomes final.

(c) *What the annuitant should do if he or she receives an advance written notice.* If the annuitant agrees with the advance written notice, he or she does not need to take any action. If the annuitant desires further information or disagrees with what the Board has told

him or her, the annuitant should immediately write or visit a Board office. If the annuitant believes he or she is now disabled, the annuitant should tell the Board why. The annuitant may give the Board any additional or new information, including reports from doctors, hospitals, railroad or non-railroad employers, or others that he or she believes the Board should have. The annuitant should send these as soon as possible to a Board office.

(d) *When the Board will not give the annuitant advance written notice.* The Board will not give the annuitant advance written notice when the Board determines that he or she is not now disabled if the Board recently told the annuitant that—

(1) The information the Board has shows that he or she is not disabled;

(2) The Board was gathering more information; and

(3) The disability annuity would stop.

§ 220.184 If the annuitant becomes disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which the last impairment(s) ends, the Board will find that disability is continuing. The impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep the annuitant from doing substantial gainful activity, or severe enough so that he or she is still disabled.

§ 220.185 The Board may conduct a review to find out whether the annuitant continues to be disabled.

After the Board finds that the annuitant is disabled, the Board must evaluate the annuitant's impairment(s) from time to time to determine if the annuitant is still eligible for disability cash benefits. The Board calls this evaluation a continuing disability review. The Board may begin a continuing disability review for any number of reasons including the annuitant's failure to follow the provisions of the Railroad Retirement Act or these regulations. When the Board begins such a review, the Board will notify the annuitant that the Board is reviewing the annuitant's eligibility for disability benefits, why the Board is reviewing the annuitant's eligibility, that in medical reviews the medical improvement review standard will apply, that the Board's review could result in the termination of the annuitant's benefits, and that the annuitant has the right to submit medical and other evidence for the Board's consideration during the continuing disability review. In doing a medical review the Board will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that the annuitant is no longer under a disability. If this review shows that the Board should stop payment of cash benefits, the Board will notify the annuitant in writing and give the annuitant an opportunity to appeal. In § 220.186 the Board describes those events that may prompt it to review whether the annuitant continues to be disabled.

§ 220.186 When and how often the Board will conduct a continuing disability review.

(a) *General.* The Board conducts continuing disability reviews to determine whether or not the annuitant continues to meet the disability requirements of the law. Payment of cash benefits or a period of disability ends if the medical or other evidence shows that the annuitant is not disabled under the standards set out in section 2 of the Railroad Retirement Act or section 223(f) of the Social Security Act.

(b) *When the Board will conduct a continuing disability review.* A continuing disability review will be started if—

(1) The annuitant has been scheduled for a medical improvement expected diary review;

(2) The annuitant has been scheduled for a periodic review in accordance with the provisions of paragraph (d) of this section;

(3) The Board needs a current medical or other report to see if the annuitant's disability continues. (This could happen when, for example, an advance in medical technology, such as improved treatment for Alzheimer's disease or a change in vocational therapy or technology raises a disability issue.);

(4) The annuitant returns to work and successfully completes a period of trial work;

(5) Substantial earnings are reported to the annuitant's wage record;

(6) The annuitant tells the Board that he or she has recovered from his or her disability or that he or she has returned to work;

(7) A State Vocational Rehabilitation Agency tells the Board that—

(i) The services have been completed; or

(ii) The annuitant is now working; or

(iii) The annuitant is able to work;

(8) Someone in a position to know of the annuitant's physical or mental condition tells the Board that the annuitant is not disabled, that the annuitant in not following prescribed treatment, that the annuitant has returned to work, or that the annuitant is failing to follow the provisions of the Social Security Act, the Railroad Retirement Act, or these regulations, and it appears that the report could be substantially correct; or

(9) Evidence the Board receives raises a question as to whether the annuitant's disability continues.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for a medical improvement excepted diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated. The term ''medical improvement expected diary'' also includes a case which is scheduled for a review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability requirement of the law is no longer met. Generally, the diary period will be the length of the training, therapy, or program of education.

Permanent impairment medical improvement not expected—refers to a case in which any medical improvement in the person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability program to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under § 220.178(c)(4), will not be considered in deciding if an impairment is permanent. Examples of permanent impairments are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in appendix 1.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1.

(4) Amputation of leg at hip.

Nonpermanent impairment refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

(d) *Frequency of review.* If an annuitant's impairment is expected to improve, generally the Board will review the annuitant's continuing eligibility for disability benefits at intervals from 6 months to 18 months following the Board's most recent decision. The Board's notice to the annuitant about the review of the annuitant's case will tell the annuitant more precisely when the review will be conducted. If the annuitant's disability is not considered permanent but is such that any medical improvement in the annuitant's impairment(s) cannot be accurately

predicted, the Board will review the annuitant's continuing eligibility for disability benefits at least once every 3 years. If no medical improvement is expected in the annuitant's impairment(s), the Board will not routinely review the annuitant's continuing eligibility. Regardless of the annuitant's classification, the Board will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that the annuitant's impairment has improved, is expected to improve, or has worsened since the last review, the Board may reclassify the annuitant's impairment to reflect this change in severity. A change in the classification of the annuitant's impairment will change the frequency with which the Board will review the case. The Board may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If the annuitant was found eligible to receive or to continue to receive disability benefits on the basis of a decision by a hearings officer, the three-member Board or a Federal court, the agency will not conduct a continuing disability review earlier than 3 years after that decision unless the annuitant's case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by the Board at least once every 3 years unless the Board determines that the requirements should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Therefore, an annuitant's continuing disability review may be delayed longer than 3 years following the Board's original decision or other review under certain circumstances. Such a delay would be based on the Board's need to ensure that backlogs, and new disability claims workloads are accomplished within available medical and other resources and that such reviews are done carefully and accurately.

[56 FR 12980, Mar. 28, 1991, as amended at 65 FR 20372, Apr. 17, 2000]

§ 220.187 If the annuitant's medical recovery was expected and the annuitant returned to work.

If the annuitant's impairment was expected to improve and the annuitant returned to full-time work with no significant medical limitations and acknowledges that medical improvement has occurred, the Board may find that the annuitant's disability ended in the month he or she returned to work. Unless there is evidence showing that the annuitant's disability has not ended, the Board will use the medical and other evidence already in the annuitant's file and the fact that he or she has returned to full-time work without significant limitations to determine that the annuitant is no longer disabled. (If the annuitant's impairment is not expected to improve, the Board will not ordinarily review his or her claim until the end of the trial work period, as described in § 220.170.)

Example: Evidence obtained during the processing of the annuitant's claim showed that the annuitant had an impairment that was expected to improve about 18 months after the annuitant's disability began. The Board, therefore, told the annuitant that his or her claim would be reviewed again at that time. However, before the time arrived for the annuitant's scheduled medical reexamination, the annuitant told the Board that he or she had returned to work and the annuitant's impairment had improved. The Board investigated immediately and found that, in the 16th month after the annuitant's began, the annuitant returned to full-time work without any significant medical restrictions. Therefore, the Board would find that the annuitant's disability ended in the first month the annuitant returned to full-time work.

APPENDIX 1 TO PART 220—LISTING OF IMPAIRMENTS

In the Listing of Impairments, the listings under each separate body system in both Part A and Part B will be effective for periods ranging from 4 to 8 years unless extended or revised and promulgated again. Specifically, the body system listings in the Listing of Impairments will be subject to the following termination dates:

Musculoskeletal system (1.00) within 5 years. Consequently, the listings in this body system will no longer be effective on June 6, 1992.

Respiratory system (3.00) within 6 years. Consequently, the listings in this body system will no longer be effective on December 6, 1991.

The cardiovascular system (4.00) will no longer be effective on June 6, 1991.

The listings under the other body systems in Part A and Part B will expire in 8 years. Consequently, the listing in these body systems will no longer be effective on December 6, 1993. The mental disorders listings in Part A will no longer be effective on August 28, 1991, unless extended by the Board or revised and promulgated again.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.

1.00 Musculoskeletal System.
2.00 Special Senses and Speech.
3.00 Respiratory System.
4.00 Cardiovascular System.
5.00 Digestive System.
6.00 Genito-Urinary System.
7.00 Hemic and Lymphatic System.
8.00 Skin.
9.00 Endocrine System.
10.00 Multiple Body Systems.
11.00 Neurological.
12.00 Mental Disorders.
13.00 Neoplastic Diseases, Malignant.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine,* associated with vertebrogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms. The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00–11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the examination and not simply a report of the individual's allegation, e.g., he says his leg is week, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising

test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion are* based on the techniques described in the ''Joint Motion Method of Measuring and Recording,'' published by the American Academy of Orthopedic Surgeons in 1965, or the ''Guides to the Evaluation of Permanent Impairment—The Extremities and Back'' (Chapter I); American Medical Association, 1971.

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or

2. Antinuclear antibodies; or

3. Elevated sedimentation rate; or

4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 *Arthritis of one major joint in each of the upper extremities (due to any cause):*

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 *Disorders of the spine:*

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30½ or more of flexion measured from the neutral position, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus puplosus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 *Osteomyelitis or septic arthritis (established by X-ray):*

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 *Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):*

A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 *Amputation of one lower extremity (at or above the tarsal region):*

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

1. Vascular disease; or

2. Neurological complications (e.g., loss of position sense); or

3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or

4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 *Fracture of the femur, tibia, tarsal bone of pelvis* with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 *Fractures of an upper extremity* with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 *Soft tissue injuries of an upper or lower extremity* requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 Special Senses and Speech

A. *Ophthalmology*

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of central or peripheral vision. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral vision restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual testing.

2. *Central visual acuity.* A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. *Field of vision.* Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lens), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charts, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology,* 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in Table 2.

4. *Muscle function.* Paralysis of the third cranial nerve producing ptosis, paralysis of

accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See Tables No. 1 and 2, following 2.09.)

6. *Special situations.* Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairement. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. *Statutory blindness.* The term ''statutory blindness'' refers to the degree of visual impairment which defines the term ''blindness'' in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. *Otolaryngology*

1. *Hearing impairment.* Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6–1969 and ANSI S 3.13–1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1–1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical examination and audiologic evaluations must be submitted.

Cases of alleged ''deaf mutism'' should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. *Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease.* These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of ''dizziness'' which is described as lightheadedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be longlasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. *Organic loss of speech.* Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00–11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Impairment of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of peripheral visual fields in the better eye.*

A. To 10½ or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20½; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency.* Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency=the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia.*

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease),* characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximal levels, in the better ear, determined by the simple average of hearing threshold levels at 500, 1000 and 2000 hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard understood and sustained.

1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500½.

2. The percent of visual field efficiency is obtained by adding the number of degrees of the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30½ in the temporal and down and out meridians and to 20½ in the remaining six meridians. The percent of visual field efficiency of this field is: $6 \times 20 + 2 \times 30 = 180 \div 500 = 0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

TABLE NO. 1—PERCENTAGE OF CENTRAL VISUAL EFFICIENCY CORRESPONDING TO CENTRAL VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)

Snellen		Percent central visual efficiency		
English	Metric	Phakic [1]	Aphakic monocular [2]	Aphakic binocular [3]
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	.....	22
20/200	6/60	20	.....	.....

Column and Use.

[1] Phakic.—1. A lens is present in both eyes. 2. A lens is present in the better eye and absent in the poorer eye. 3. A lens is present in one eye and the other eye is enucleated.

[2] Monocular.—1. A lens in absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction in 20/200 or less. 3. A lens is absent from one eye and the other eye is enucleated.

[3] Binocular.—1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.

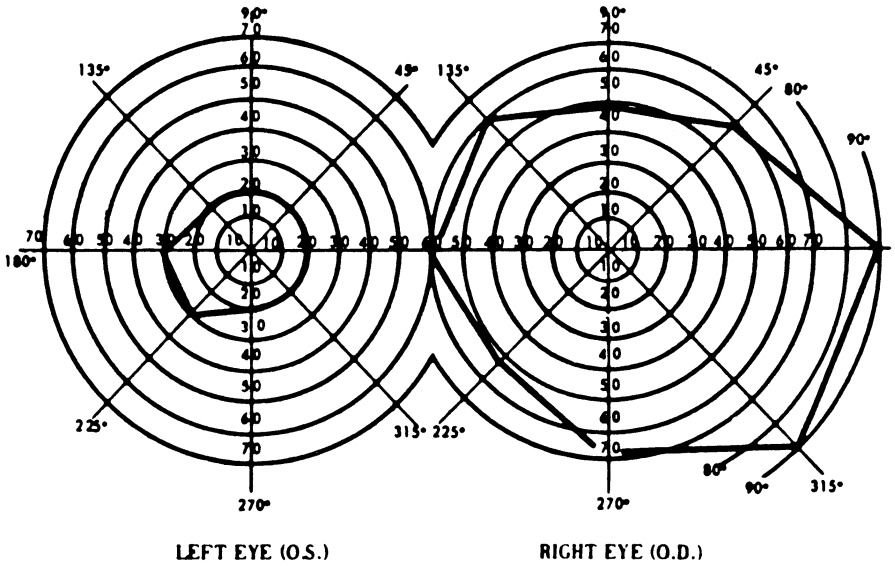

TABLE NO. 2—CHART OF VISUAL FIELD SHOWING EXTENT OF NORMAL FIELD AND METHOD OF COMPUTING PERCENT OF VISUAL FIELD EFFICIENCY

3.00 RESPIRATORY SYSTEM

A. *Introduction:* Impairments caused by the chronic disorder of the respiratory system generally result from irreversible loss of pulmonary functional capacity (ventilatory impairment, gas exchange impairment, or a combination of both). The most common symptom attributable to these disorders is dyspnea on exertion. Cough, wheezing, sputum production, hemoptysis, and chest pain may also occur, but need not be present. However, since these symptoms are common to many other diseases, evaluation of impairments of the respiratory system requires a history, physical examination, and chest roentgenogram to establish the diagnosis of a chronic respiratory disorder. Pulmonary function testing is required to provide a basis for assessing the impairment, once the diagnosis is established by appropriate clinical findings.

Alteration of ventilatory function may be due primarily to chronic obstructive pulmonary disease (emphysema, chronic bronchitis, chronic asthmatic bronchitis) or restrictive disorders with primary loss of lung volume (pulmonary resection, thoracoplasty, chest cage deformity as seen in kyphoscoliosis), or infiltrative interstitial disorders (diffuse fibrosis). Impairment of gas exchange without significant airway obstruction may be produced by interstitial disorders (diffuse fibrosis). Primary disease of pulmonary circulation may produce pulmonary vascular hypertension and, eventually, heart failure. Whatever the mechanism, any chronic progressive pulmonary disorder may result in cor pulmonale or heart failure. Chronic infection caused, most frequently by mycobacterial or mycotic organisms, may produce extensive lung destruction resulting in marked loss of pulmonary functional capacity. Some disorders such as bronchiectasis and asthma may be characterized by acute, intermittent illnesses of such frequency and intensity that they produce a marked impairment apart from intercurrent functional loss, which may be mild.

Most chronic pulmonary disorders may be adequately evaluated on the basis of history, physical examination, chest roentgenogram, and ventilatory function tests. Direct assessment of gas exchange by exercise arterial blood gas determination or diffusing capacity is required only in specific relatively rare circumstances, depending on the clinical features and specific diagnosis.

B. *Mycobacterial and mycotic infections of the lung will be evaluated* on the basis of the resulting impairment to pulmonary function. Evidence of infectious or active mycobacterial or mycotic infection, such as positive cultures, increasing lesions, or cavitation, is not, by itself, a basis for determining that the individual has a severe impairment which is expected to last 12

months. However, if these factors are abnormally persistent, they should not be ignored. For example, in those unusual cases where there is evidence of persistent pulmonary infection caused by mycobacterial or mycotic organisms for a period closely approaching 12 consecutive months, the clinical findings, complications, treatment considerations, and prognosis must be carefully assessed to determine whether, despite the absence of impairment of pulmonary function, the individual has a severe impairment that can be expected to last for 12 consecutive months.

C. *When a respiratory impairment is episodic in nature,* as may occur in complications of bronchiectasis and asthmatic bronchitis, the frequency of severe episodes despite prescribed treatment is the criterion for determining the level of impairment. Documentation for episodic asthma should include the hospital or emergency room records indicating the dates of treatment, clinical findings on presentation, what treatment was given and for what period of time, and the clinical response. Severe attacks of episodic asthma, as listed in section 3.03B, are defined as prolonged episodes lasting at least several hours, requiring intensive treatment such as intravenous drug administration or inhalation therapy in a hospital or emergency room.

D. *Documentation of ventilatory function tests.* The results of ventilatory function studies for evaluation under tables I and II should be expressed in liters or liters per minute (BTPS). The reported one second forced expiratory volume (FEV_1) should represent the largest of at least three attempts. One satisfactory maximum voluntary ventilation (MVV) is sufficient. The MVV should represent the observed value and should not be calculated from FEV_1. These studies should be repeated after administration of a nebulized bronchodilator unless the prebronchodilator values are 80 percent or more of predicted normal values or the use of bronchodilators is contraindicated. The values in tables I and II assume that the ventilatory function studies were not performed in the presence of wheezing or other evidence of bronchospasm or, if these were present at the time of the examination, that the studies were repeated after administration of a bronchodilator. Ventilatory function studies performed in the presence of bronchospasm, without use of bronchodilators, cannot be found to meet the requisite level of severity in tables I and II.

The appropriately labeled spirometric tracing, showing distance per second on the abscissa and the distance per liter on the ordinate, must be incorporated in the file. The manufacturer and model number of the device used to measure and record the ventilatory function should be stated. If the spirogram was generated other than by direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show the calibration of volume units through mechanical means such as would be obtained using a giant syringe. The FEV_1 must be recorded at a speed of at least 20 mm. per second. Calculation of the FEV_1 from a flow volume loop is not acceptable. The recording device must provide a volume excursions of at least 10 mm. per liter. The MVV should be represented by the tidal excursions measured over a 10- to 15-second interval. Tracings showing only cumulative volume for the MVV are not acceptable. The ventilatory function tables are based on measurement of the height of the individual without shoes. Studies should not be performed during or soon after an acute respiratory illness. A statement should be made as to the individual's ability to understand the directions and cooperate in performing the test.

E. *Documentation of chronic impairment of gas exchange—Arterial blood gases and exercise tests.*

1. *Introduction:* Exercise tests with measurement of arterial blood gases at rest and during exercise should be purchased when not available as evidence of record in cases in which there is documentation of chronic pulmonary disease, but the existing evidence, including properly performed ventilatory function tests, is not adequate to evaluate the level of the impairment. Before purchasing arterial blood gas tests, medical history, physical examination, report of chest roentgenogram, ventilatory function tests, electrocardiographic tracing, and hematocrit must be obtained and should be evaluated by a physician competent in pulmonary medicine. Arterial blood gas tests should not be purchased where full development short of such purchase reveals that the impairment meets or equals any other listing or when the claim can be adjudicated on some other basis. Capillary blood analysis for PO_2 or PCO_2 is not acceptable. Analysis of arterial blood gases obtained after exercise is stopped is not acceptable.

Generally individuals with an FEV_1 greater than 2.5 liters or an MVV greater than 100 liters per minute would not be considered for blood gas studies unless diffuse interstitial pulmonary fibrosis was noted on chest X-ray or documented by tissue diagnosis. The exercise test facility should be provided with the clinical reports, report of chest roentgenogram, and spirometry results obtained by the DDS. The testing facility should determine whether exercise testing is clinically contraindicated. If an exercise test is clinically contraindicated, the reason for exclusion from the test should be stated in the report of the exercise test facility.

2. *Methodology.* Individuals considered for exercise testing first should have resting PaO_2, $PaCO_2$, and pH determinations by the

testing facility. The samples should be obtained in the sitting or standing position. The individual should be exercised under steady state conditions, preferably on a treadmill for a period of 6 minutes at a speed and grade providing a workload of approximately 17 ml. O_2/kg./min. If a bicycle ergometer is used, an exercise equivalent of 450 kgm./min., or 75 watts, should be used. At the option of the facility, a warm-up period of treadmill walking may be performed to acquaint the applicant with the procedure. If, during the warm-up period, the individual cannot exercise at the designated level, a lower speed and/or grade may be selected in keeping with the exercise capacity estimate. The individual should be monitored by electrocardiogram throughout the exercise and representative strips taken to provide heart rate in each minute of exercise. During the 5th or 6th minute of exercise, an arterial blood gas sample should be drawn and analyzed for PO_2, PCO_2, and pH. If the facility has the capability, and at the option of the DDS and the facility, minute ventilation (BTPS) and oxygen consumption per minute (STPD) and CO_2 production (STPD) should be measured during the 5th or 6th minute of exercise. If the individual fails to complete 6 minutes of exercise, the facility should comment on the reason.

The report should contain representative strips of electrocardiograms taken during the exercise, hematocrit, resting and exercise arterial blood gas value, speed and grade of the treadmill or bicycle ergometer exercise level in watts or kgm./min., and duration of exercise. The altitude of the test site, barometric pressure, and normal range of blood gas values for that facility should also be reported.

3. *Evaluation.* Three tables are provided in Listing 3.02C1 for evaluation of arterial blood gas determinations at rest and during exercise. The blood gas levels in Listing 3.02C1, Table III-A, are applicable at test sites situated at less than 3,000 feet above sea level. The blood gas levels in Listing 3.02C1, Table III-B, are applicable at test sites situated at 3,000 through 6,000 feet above sea level. The blood gas levels in Listing 3.02C1, Table III-C, are applicable for test sites over 6,000 feet above sea level. Tables III-B and C, take into account the lower blood PaO_2 normally found in individuals tested at the higher altitude. When the barometric pressure is unusually high for the altitude at the time of testing, consideration should be given to those cases in which the PaO_2 falls slightly above the requirements of Table III-A, III-B, or III-C, whichever is appropriate for the altitude at which testing was performed.

3.01 Category of Impairments, Respiratory

3.02 *Chronic Pulmonary Insufficiency.*

With:

A. Chronic obstructive pulmonary disease (due to any cause). With: Both FEV_1 and MVV equal to or less than values specified in Table I corresponding to the person's height without shoes.

TABLE I

Height without shoes (inches)	FEV_1 and MVV	
	Equal to or less than (L, BTPS)	(MBC) equal to or less than (L/min., BTPS)
60 or less	1.0	40
61–63	1.1	44
64–65	1.2	48
66–67	1.3	52
68–69	1.4	56
70–71	1.5	60
72 or more	1.6	64

or

B. *Chronic restrictive ventilatory disorders.* With: Total vital capacity equal to or less than values specified in Table II corresponding to the person's height without shoes. In severe kyphoscoliosis, the measured span between the fingertips when the upper extremities are abducted 90 degrees should be substituted for height.

TABLE II

Height without shoes (inches)	VC equal to or less than (L, BTPS)
60 or less	1.2
61–63	1.3
64–65	1.4
66–67	1.5
68–69	1.6
70–71	1.7
72–or more	1.8

or

C. Chronic impairment of gas exchange (due to any cause). With:

1. Steady-state exercise blood gases demonstrating values of PaO_2 and simultaneously determined $PaCO_2$, measured at a workload of approximately 17 ml. O_2/kg./min. or less of exercise, equal to or less than the values specified in Table III-A or III-B or III-C.

TABLE III—A

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg)	Arterial PO_2 and equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59

TABLE III—A—Continued

[Applicable at test sites less than, 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg)	Arterial PO_2 and equal to or less than (mm. Hg)
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg)	Arterial PCO_2 and equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	56
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

or

2. Diffusing capacity for the lungs for carbon monoxide less than 6 ml./mm. Hg/min. (steady-state methods) or less than 9 ml./mm. Hg/min. (single breath method) or less than 30 percent of predicted normal. (All method, actual values, and predicted normal values for the methods used should be reported.): or

D. Mixed obstructive ventilatory and gas exchange impairment. Evaluate under the criteria in 3.02A, B, and C.

3.03 *Asthma*. With:

A Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive ventilatory impairment in 3.02A, or

B. Episodes of severe attacks (See 3.00C), in spite of prescribed treatment, occurring at least once every 2 months or on an average of at lest 6 times a year, and prolonged expiration with wheezing or rhonchi on physical examination between attacks.

3.06 *Pneumoconiosis (demonstrated by roentgenographic evidence)*. Evaluate under criteria in 3.02.

3.07 *Bronchiectasis (demonstrated by radiopaque material)*. With:

A. Episodes of acute bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) occurring at least every 2 months; or

B. Impairment of pulmonary function due to extensive disease should be evaluated under the applicable criteria in 3.02.

3.08 *Mycobacterial infection of the lung*, Impairment of pulmonary function due to extensive disease should be evaluated under appropriate criteria in 3.02.

3.09 *Mycotic infection of the lung*, Impairment of pulmonary function due to extensive disease should be evaluated under the appropriate criteria in 3.02.

3.11 *Cor pulmonale, or pulomonary vascular hypertension*. Evaluate under the criteria in 4.02D.

4.00 CARDIOVASCULAR SYSTEM

A. *Severe cardiac impairment* results from one or more of three consequences of heart disease; (1) congestive heart failure; (2) ischemia (with or without necrosis) of heart muscle; (3) conduction disturbances and/or arrhythmias resulting in cardiac syncope.

With diseases of arteries and veins, severe impairment may result from disorders of the vasculature in the central nervous system, eyes, kidneys, extremities, and other organs.

The criteria for evaluating impairment resulting from heart diseases or diseases of the blood vessels are based on symptoms, physical signs and pertinent laboratory findings.

B. *Congestive heart failure* is considered in the Listing under one category whatever the etiology (i.e., arteriosclerotic, hypertenaive, rheumatic, pulmonary, congenital, or other organic heart diseases). Congestive heart failure is not considered to have been established for the purpose of 4.02 unless there is evidence of vascular congestion such as hepatomegaly or peripheral or pulmonary edema which is consistent with clinical diagnosis. (Radiological description of vascular congestion, unless supported by appropriate clinical evidence, should not be construed as pulmonary edema.) The findings of vascular congestion need not be present at the time of adjudication (except for 4.02A), but must be casually related to the current episode of marked impairment. The findings other than vascular congestion must be persistent.

Other congestive, ischemic, or restrictive (obstructive) heart diseases such as caused by cardiomyopathy or aortic stenosis may result in signficant impairment dues to congestive heart failure, rhythm disturbances, or ventricular outflow obstruction in the absence of left ventricular enlargement as described in 4.02B1. However, the ECG criteria as defined in 4.02B2 should be fulfilled. Clinical findings such as symptions of dyspnea, fatigue, rhythm disturbances, etc., should be documented and the diagnosis confirmed by echocardiography or at cardiac catheterization.

C. *Hypertensive vascular diseases* does not result in severe impairment unless it causes severe damage to one or more of four end organs; heart, brain, kidneys, or eyes. (retinae). The presence of such damage must be established by appropriate abnormal physical signs and laboratory findings as specified in 4.02 or 4.04, or for the body system involved.

D. *Ischemic heart diseases* may result in a marked impairment due to chest pain. Description of the pain must contain the clinical characteristics as discussed under 4.00E. In addition, the clinical impression of chest pain of cardiac origin must be supported by objective evidence as described under 4.00 F.G. or H.

E. *Chest pain of cardic origin* is considered to be pain which is precipitated by effort and promptly relieved by sublingual nitroglycerin or rapid-acting nitrates or rest. The character of the pain is classically described as crushing squeezing, burning, or oppressive pain located in the chest. Excluded is sharp, sticking or rhythmic pain. Pain occurring on exercise should be described specifically as to usual inciting factors (kind and degree), character, location, radiation, duration, and responses to nitroglycerin or rest.

So-called ''anginal equivalent'' locations manifested by pain in the throat, arms, or hands have the same validity as the chest pain described above. Status anginosus and variant angina of the Prinzmetal type (e.g., rest angina with transitory ST elevation on electrocardiogram) will be considered to have the same validity as classical angina pectoris as described above. Shortness of breath as an isolated finding should not be considered as an anginal equivalent.

Chest pain that appears to be of cardiac origin may be caused by noncoronary conditions. Evidence for the latter should be actively considered in determining whether the chest pain is of cardiac origin. Among the more common conditions which may masquerade as angina are gastrointestinal tract lesions such as biliary tract disease, esophagitis, hiatal hernia, peptic ulcer, and pancreatitis; and musculoskeletal lesions such as costochondritis and cervical arthritis.

F. *Documentation of electrocardiography.*

1. *Electrocardiograms obtained at rest* must be submitted in the original or a legible copy of a 12-lead tracing appropriately labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large ORS amplitudes) must be shown on those leads.

The effect of drugs, electrolyte imbalance, etc., should be considered as possible noncoronary causes of ECG abnormalities, especially those involving the ST segment. If needed and available, pre-drug (especially predigitalis) tracing should be obtained.

The term ''ischemic'' is used in 4.04 to describe a pathologic ST deviation. Nonspecific repolarization changes should not be confused with ischemic configurations or a current of injury.

Detailed descriptions or computer interpretations without the original or legible copies of the ECG are not acceptable.

2. *Electrocardiograms obtained in conjunction with exercise tests* must include the original tracings or a legible copy of appropriate leads obtained before, during, and after exercise. Test control tracings, taken before exercise in the upright position, must be obtained. An ECG after 20 seconds of vigorous hyperventilation should be obtained. A posthyperventilation tracing may be essential for the proper evaluation of an ''abnormal'' test in certain circumstances, such as in women with evidence of mitral valve prolapse. A tracing should be taken at approximately 5 METs of exercise and at the time the ECG becomes abnormal according to the criteria in 4.04A. The time of onset of these abnormal changes must be noted, and the ECG tracing taken at the time should be obtained. Exercise histograms without the original tracings or legible copies are not acceptable.

Whenever electrocardiographically documented stress test data are submitted, irrespective of the type, the standardization must be inscribed on the tracings and the strips must be labeled appropriately, indicating the times recorded. The degree of exercise achieved, the blood pressure levels during the test, and any reason for terminating the test must be included in the report.

G. *Exercise testing.*

1. *When to purchase.* Since the results of a treadmill exercise test are the primary basis for adjudicating claims under 4.04, they should be included in the file whenever they have been performed. There are also circumstances under which it will be appropriate to purchase exercise tests. Generally, these are limited to claims involving chest pain which is considered to be of cardiac origin but without corroborating ECG or other evidence of ischemic heart disease.

Exercise test should not be purchased in the absence of alleged chest pain of cardiac

origin. Even in the presence of an allegation of chest pain of cardiac origin, an exercise test should not be purchased where full development short of such a purchase reveals that the impairment meets or equals any Listing or the claim can be adjudicated on some other basis.

2. *Methodology*. When an exercise test is purchased, it should be a treadmill type using a continuous progressive multistage regimen. The targeted heart rate should be not less than 85 percent of the maximum predicted heart rate unless it becomes hazardous to exercise to the heart rate or becomes unnecessary because the ECG meets the criteria in 4.04A at a lower heart rate (see also 4.00F.2). Beyond these requirements, it is prudent to accept the methodology of a qualified, competent test facility. In any case, a precise description of the protocol that was followed must be provided.

3. *Limitations of exercise testing*. Exercise testing should not be purchased for individuals who have the following: unstable progressive angina pectoris; recent onset (approximately 2 months) of angina; congestive heart failure; uncontrolled serious arrhythmias (including uncontrolled auricular fibrillation); second or third-degree heart block; Wolff-Parkinson-White syndrome; uncontrolled marked hypertension; marked aortic stenosis; marked pulmonary hypertension; dissecting or ventricular aneurysms; acute illness; limiting neurological or musculoskeletal impairments; or for individuals on medication where performance of stress testing may constitute a significant risk.

The presence of noncoronary or nonischemic factors which may influence the ECG response to exercise include hypokalemia, hyperventilation, vasoregulatory asthenia, significant anemia, left bundle branch block, and other heart disease, particularly valvular.

Digitalis may cause ST segment abnormalities at rest, during, and after exercise. Digitalis-related ST depression, present at rest, may become accentuated and result in false interpretations of the ECG taken during or after exercise test.

4. *Evaluation*. Where the evidence includes the results of a treadmill exercise test, this evidence is the primary basis for adjudicating claims under 4.04. For purposes of this Social Security disability program, treadmill exercise testing will be evaluated on the basis of the level at which the test becomes positive in accordance with the ECG criteria in §404A. However, the significance of findings of a treadmill exercise test must be considered in light of the clinical course of the disease which may have occurred subsequent to performance of the exercise test. The criteria in 4.04B are not applicable if there is documentation of an acceptable treadmill exercise test, it there is no evidence of a treadmill exercise test or if the test is not acceptable, the criteria in 4.04B should be used. The level of exercise is considered in terms of multiples of MET's (metabolic equivalent units). One MET is the basal O_2 requirement of the body in an inactive state, sitting quietly. It is considered by most authorities to be approximately 3.5 ml. O_2/kg./min.

H. *Angiographic evidence*.

1. *Coronary arteriography*. This procedure is not to be purchased by the Social Security Administration. Should the results of such testing be available, the report should be considered as to the quality and kind of data provided and its applicability to the requirements of the Listing of Impairments. A copy of the report of the catheterization and ancillary studies should be obtained. The report should provide information as to the technique used, the method of assessing coronary lumen diameter, and the nature and location of any obstructive lesions.

It is helpful to know the method used, the number of projections, and whether selective engagement of each coronary vessel was satisfactorily accomplished. It is also important to know whether the injected vessel was entirely and uniformly opacified, thus avoiding the artifactual appearance of narrowing or an obstruction.

Coronary artery spasm induced by intracoronary catheterization is not to be considered as evidence of ischemic heart disease.

Estimation of the functional significance of an obstructive lesion may also be aided by description of how well the distal part of the vessel is visualized. Some patients with significant proximal coronary atherosclerosis have well-developed large collateral blood supply to the distal vessels without evidence of myocardial damage or ischemia, even under conditions of severe stress.

2. *Left ventriculography*. The report should describe the local contractility of the myocardium as may be evident from areas of hypokinesia, dyskinesia, or akinesia; and the overall contractility of the myocardium as measured by the ejection fraction.

3. *Proximal coronary arteries* (see 4.04B7) will be considered as the:

a. Right coronary artery proximal to the acute marginal branch; or

b. Left anterior descending coronary artery proximal to the first septal perforator; or

c. Left circumflex coronary artery proximal to the first obtuse marginal branch.

I. *Results of other tests*. Information from adequate reports of other tests such as radionuclide studies or echocardiography should be considered where that information is comparable to the requirements in the listing. An ejection fraction measured by echocardiography is not determinative, but may be given consideration in the context of associated findings.

J. *Major surgical procedures.* The amount of function restored and the time required to effect improvement after heart or vascular surgery vary with the nature and extent of the disorder, the type of surgery, and other individual factors. If the criteria described for heart or vascular disease are met, proposed heart or vascular surgery (coronary artery bypass procedure, valve replacement, major arterial grafts, etc.) does not militate against a finding of disability with subsequent assessment postoperatively.

The usual time after surgery for adequate assessment of the results of surgery is considered to be approximately 3 months. Assessment of the magnitude of the impairment following surgery requires adequate documentation of the pertinent evaluations and tests performed following surgery, such as an interval history and physical examination, with emphasis on those signs and symptoms which might have changed postoperatively, as well as X-rays and electrocardiograms. Where treadmill exercise tests or angiography have been performed following the surgical procedure, the results of these tests should be obtained.

Documentation of the preoperative evaluation and a description of the surgical procedure are also required. The evidence should be documented from hospital records (catheterization reports, coronary arteriographic reports, etc.) and the operative note.

Implantation of a cardiac pacemaker is not considered a major surgical procedure for purposes of this section.

K. *Evaluation of peripheral arterial disease.* The evaluation of peripheral arterial disease is based on medically acceptable clinical findings providing adequate history and physical examination findings describing the impairment, and on documentation of the appropriate laboratory techniques. The specific findings stated in Listing 4.13 represent the level of severity of that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. The level of the impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, and/or angiographic findings.

The requirements for evaluation of peripheral arterial disease in Listing 4.13B are based on the ratio of systolic blood pressure at the ankle, determined by Doppler study, to the systolic blood pressure at the brachial artery determined at the same time. Results of plethysmographic studies, or other techniques providing systolic blood pressure determinations at the ankle, should be considered where the information is comparable to the requirements in the listing.

Listing 4.13B.1 provides for determining that the listing is met when the resting ankle/brachial systolic blood pressure ratio is less than 0.50. Listing 4.13B.2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting ankle/brachial systolic blood pressure ratio is 0.50 or above. The results of exercise studies should describe the level of exercise (e.g., speed and grade of the treadmill settings), the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent levels measured after exercise, and the time required to return the systolic blood pressure toward or to, the preexercise level. When exercise Doppler studies are purchased by the Social Security Administration, it is suggested that the requested exercise be on a treadmill at 2 mph. on a 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise is contraindicated. The methodology of a qualified, competent facility should be accepted. In any case, a precise description of the protocol that was followed must be provided.

It must be recognized that application of the criteria in Listing 4.13B may be limited in individuals who have severe calcific (Monckeberg's) sclerosis of the peripheral arteries or severe small vessel disease in individuals with diabetes mellitus.

4.01 Category of Impairments, Cardiovascular System

4.02 *Congestive heart failure (manifested by evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema).* With:

A. Persistent congestive heart failure on clinical examination despite prescribed therapy; or

B. Persistent left ventricular enlargement and hypertrophy documented by both:

1. Extension of the cardiac shadow (left ventricle) to the vertebral column on a left lateral chest roentgenogram; and

2. ECG showing QRS duration less than 0.12 second with S_{v1} plus R_{v5} (or R_{v6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T waves in leads with tall R waves: or

C. Persistent ''mitral'' type heart involvement documented by left atrial enlargement shown by double shadow on PA chest roentgenogram (or characteristic distortion of barium-filled esophagus) and either;

1. ECG showing QRS duration less than 0.12 second with S_{v1} plus R_{v5} (or R_{v6}) of 35 mm. or greater *and* ST segment depressed more than 0.5 mm. *and* low, diphasic or inverted T wavers in leads with tall R waves, or

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6; or

D. Cor pulmonale (non-acute) documented by both:

1. Right ventricular enlargement (or prominence of the right out-flow tract) on chest roentgenogram or fluoroscopy; and

2. ECG evidence of right ventricular hypertrophy with R wave of 5.0 mm. or greater in lead V_1 *and* progressive decrease in R/S amplitude from lead V_1 to V_5 or V_6

4.03 *Hypertensive vascular disease.* Evaluate under 4.02 04 4.04 or under the criteria for the affected body system.

4.04 *Ischemic heart disease with chest pain or cardiac origin as described in 4.00E* With:

A. Treadmill exercise test (see 4.00 F and (G) demonstrating one of the following at an exercise level of 5 METs or less:

1. Horizontal or downsloping depression (from the standing control) of the ST segment to 1.0 mm. or greater, lasting for at least 0.08 second after the J junction, and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

2. Junctional depression occurring during exercise, remaining depressed (from the standing control) to 2.0 mm. or greater for at least 0.08 second after the J junction (the so-called slow upsloping ST segment), and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

3. Premature ventricular systoles which are multiform or bidirectional or are sequentially inscribed (3 or more); or

4. ST segment elevation (from the standing control) to 1 mm. or greater; or

5. Development of second or third degree heart block; or

B. In the absence of a report of an acceptable treadmill exercise test (see 4.00G), one of the following:

1. Transmural myocardial infarction exhibiting a QS pattern or a Q wave with amplitude at least ⅓rd of R wave and with a duration of 0.04 second or more. (If these are present in leads III and a VF only, the requisite Q wave findings must be shown, by labelled tracing, to persist on deep inspiration); or

2. Resting ECG findings showing ischemic-type (see §4.00F1) depression of ST segment to more than 0.5 mm. in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6; or

3. Resting ECG findings showing an ischemic configuration or current of injury (see 4.00F1) with ST segment elevation to 2 mm. or more in either (a) leads I and a VL and V_6 or (b) leads II and III and a VF or (c) leads V_3 through V_6; or

4. Resting ECG findings showing symmetrical inversion of T waves to 5.0 mm. or more in any two leads except leads III or aVR or V_1 or V_2; or

5. Inversion of T wave to 1.0 mm. or more in any of leads I, II, aVL, V_2 to V_6 *and* R wave of 5.0 mm. or more in lead aVL *and* R wave greater than S wave in lead aVF; or

6. ''Double'' Master Two-Step test demonstrating one of the following:

a. Ischemic depression of ST segment to more than 0.5 mm. lasting for at least 0.08 second beyond the J junction and clearly discernible in at least two consecutive complexes which are on a level baseline in any lead; or

b. Development of a second or third degree heart block; or

7. Angiographic evidence (see 4.00H) (obtained independent of Social Security disability evaluation) showing one of the following:

a. 50 percent or more narrowing of the left main coronary artery; or

b. 70 percent or more narrowing of a *proximal* coronary artery (see 4.00H3) (excluding the left main coronary artery); or

c. 50 percent or more narrowing involving a long (greater than 1 cm.) segment of a proximal coronary artery or multiple proximal coronary arteries; or

8. Akinetic or hypokinetic myocardial wall or septal motion with left ventricular ejection fraction of 30 percent of less measured by contrast or radio-isotopic ventriculographic methods; or

C. Resting ECG findings showing left bundle branch block as evidenced by QRS duration of 0.12 second or more in leads I, II, or III *and* R peak duration of 0.06 second or more in leads I, aVL, V_5, or V_6, unless there is a coronary angiogram of record which is negative (see criteria in 4.04B7).

4.05 *Recurrent arrhythmias* (not due to digitalis toxicity) resulting in uncontrolled repeated episodes of cardiac syncope and documented by resting or ambulatory (Holter) electrocardiography.

4.09 *Myocardiopathies, rheumatic or syphilitic heart disease.* Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.11 *Aneurysm of aorta or major branches* (demonstrated by roentgenographic evidence). With:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment; or

B. Congestive heart failure as described under the criteria in 4.02; or

C. Renal failure as described under the criteria in 6.02; or

D. Repeated snycopal episodes.

4.12 *Chronic venous insufficiency* of the lower extremity with incompetency or obstruction of the deep venous return, associated with superficial varicosities, extensive brawny edema, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.13 *Peripheral arterial disease.* With:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity; or

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at ankle or exercise (see 4.00K) to 50 percent or more of preexercise level *and* requiring 10 minutes or more to return to prexercise level; or

C. Amputation at or above the tarsal region due to peripheral arterial disease.

5.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders.* When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract,* including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic examinations despite therapy to be considered a severe impairment which will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause* with anemia manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under §5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy).* With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. or

D. Weight loss as described under §5.08.

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease).* With:

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under §5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under §5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder:* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in Table I or II; or

B. Weight equal to or less than the values specified in Table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm, or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex—To be used only in connection with 5.08.

TABLE I—MEN

Height (inches) [1]	Weight (pounds)
61	90
62	92
63	94
64	97

TABLE I—MEN—Continued

Height (inches) [1]	Weight (pounds)
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

[1] Height measured without shoes.

TABLE II—WOMEN

Height (inches) [1]	Weight (pounds)
58	77
59	79
60	82
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107
70	110
71	114
72	117
73	120

[1] Height measured without shoes.

TABLE III—MEN

Height (inches) [1]	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129
73	133
74	136
75	139
76	143

[1] Height measured without shoes.

TABLE IV—WOMEN

Height (inches) [1]	Weight (pounds)
58	82
59	84
60	87
61	89

TABLE IV—WOMEN—Continued

Height (inches) [1]	Weight (pounds)
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

[1] Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritioneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neunropathy, etc.) and side effects of corticosteroids or immuno-suppressive agents. A convalesent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications* according to the appropriate body system Listing.

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

1. Renal osteodystrophy manifested by severe bone pain and appropriate radiographic abnormalities (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, Table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy.* With:

A. Serum albumin of 3.0 gm. per deciler (100 ml.) or less *and* protenuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated by* persistence of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with antihemophilic globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 Category of Impairments, Hemic and Lymphatic System

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of §7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17, or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresias. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

7.16 *Myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).* With:

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will

last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problems, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 10.04 and 10.05. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 Category of Impairments, Skin

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections. With extensive fungating, ulcerating lesions not responding to prescribed treatment.*

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involvement of the hands or feet which impose a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amendable to surgical treatment.

9.00 Endocrine System

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

9.01 Category of Impairments, Endocrine

9.02 *Thyroid Disorders.* With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism.* With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism.* With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus).* With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex.* Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus.* With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or pCO2 or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

10.00 Multiple Body Systems

A. The impairments included in this section usually involve more than a single body system.

B. Long-term obesity will usually be associated with disorders in the musculoskeletal, cardiovascular, peripheral vascular, and pulmonary systems, and the advent of such disorders is the major cause of impairment. Extreme obesity results in restrictions imposed by body weight and the additional restrictions imposed by disturbances in other body systems.

10.01 Category of Impairments, Multiple Body Systems

10.02 *Hansen's disease (leprosy).* As active disease or consider as ''under a disability'' while hospitalized.

10.03 *Polyarteritis or periarteritis nodosa (established by biopsy).* With signs of generalized arterial involvement.

10.04 *Disseminated lupus erythematosus (established by a positive LE preparation or biopsy or positive ANA test).* With frequent exacerbations demonstrating involvement of renal or cardiac or pulmonary or gastrointestinal or central nervous systems.

10.05 *Scleroderma or progressive systemic sclerosis (the diffuse or generalized form).* With:

A. Advanced limitation of use of hands due to sclerodactylia or limitation in other joints; or

B. Significant visceral manifestations of digestive, cardiac, or pulmonary impairment.

10.10 *Obesity.* Weight equal to or greater than the values specified in Table I for

males, Table II for females (100 percent above desired level) and one of the following:

A. History of pain and limitation of motion in any weight bearing joint or spine (on physical examination) associated with X-ray evidence of arthritis in a weight bearing joint or spine; or

B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or

C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or

D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or

E. Respiratory disease with total forced vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III-A or III-B or III-C.

TABLE I—MEN

Height without shoes (inches)	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

TABLE II—WOMEN

Height without shoes (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

TABLE III—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO^2 (mm. Hg) and	Arterial PO^2 equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO^2 (mm. Hg) and	Arterial PO^2 equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

11.00 NEUROLOGICAL

A. *Convulsive disorders.* In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of

a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electronencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurrring at the frequency stated in 11.02 or 11.03, evalution of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption of metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. *Brain tumors.* The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. *Persistent disorganization of motor function* in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory distrubances (any or all of which may be due to cerebral cerbellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combination, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms.

D. *In conditions which are episodic in character,* such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. *Multiple sclerosis.* The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness or other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis, and (3) obtaining evidence that the system has actually become fatigued. The evaluation of the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduced with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

11.01 Category of Impairments, Neurological

11.02 *Epilepsy—major motor seizures, (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment.* With:

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment.* With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

11.04 *Central nervous system vascular accident.* With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04 A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy.* With:

A. IQ of 69 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability: or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause* with disorganization of motor function as described in 11.04B.

11.09 *Multiple sclerosis.* With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis. With:*

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.11 *Anterior poliomyelitis.* With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis.* With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies.*

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis.*

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as decribed in 11.04B or 11.15B, not significantly improved by prescribed treatment.*

11.17 *Degenerative disease not elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration.* With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma:*

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia.*

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 MENTAL DISORDERS

The mental disorders listings in 12.00 of the Listing of Impairments will no longer be effective on August 28, 1991, unless extended by the Board or revised and promulgated again.

A. *Introduction:* The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical findings.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder. (While RFC may be applicable in most claims, the law specifies that it does not apply to the following special claims categories: disabled title XVI children below age 18, widows, widowers and surviving divorced wives. The impairment(s) of these categories must meet or equal a listed impairment for the individual to be eligible for benefits based on disability.)

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. *Assessment of Severity:* For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of

the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where ''marked'' is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

''Marked'' is not the number of activities which are restricted but the overall degree of restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

''Marked'' is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. *Documentation:* The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistance and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 69 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a

single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added to Listings 12.03 and 12.06.)

G. *Effects of Medication:* Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment:* It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

I. *Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity:* A special technique has been developed to ensure that all evidence needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in §404.1520a and §416.920a.

12.01 Category of Impairments-Mental

12.02 *Organic Mental Disorders:* Psychological or behaviorial abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or

2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation

of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders:* Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders:* Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activites; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking;

or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 *Mental Retardation and Autism:* Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and

individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 to 69 inclusive or in the case of autism gross deficits of social and communicative skills with two of the following;

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 *Anxiety Related Disorders:* In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or

b. Autonomic hyperactivity; or

c. Apprehensive expectation; or

d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders:* Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or

f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 *Personality Disorders:* A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:
1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:
1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 *Substance Addiction Disorders:* Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Organic mental disorders. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04.

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

E. Peripheral neuropathies. Evaluate under 11.14.

F. Liver damage. Evaluate under 5.05.

G. Gastritis. Evaluate under 5.04.

H. Pancreatitis. Evaluate under 5.08.

I. Seizures. Evaluate under 11.02 or 11.03.

13.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation.* Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, ''distant metastases'' or ''metastases beyond the regional lymph nodes'' refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as ''inoperable.''

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated

with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of involvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy*. Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset*. To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

A. Inoperable; or

B. Not controlled by prescribed therapy; or

C. Recurrent after radical surgery or irradiation; or

D. With distant metastases; or

E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

A. Angiosarcoma with metastases to regional lymph nodes or beyond; or

B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

A. Recurrent after wide excision; or

B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or

B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where the primary site is not determined after adequate search; or

C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*— carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

A. Inoperable carcinoma; or

B. Inflammatory carcinoma; or

C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or

D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or

E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or

B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

A. Sarcoma of any type with metastases; or

B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or

C. Orbital tumors with intracranial extension; or

D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or

E. Adamantinoma with orbital or intracranial infiltration; or

F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

A. Metastatic carcinoma to brain or spinal cord.

B. Evaluate other tumors under the criteria described in 11.05 and 11.08.

13.13 *Lungs.*

A. Unresectable or with incomplete excision; or

B. Recurrence or metastases after resection; or

C. Oat cell (small cell) carcinoma; or

D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or

E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

A. Malignant mesothelioma of pleura; or

B. Malignant tumors, metastatic to pleura; or

C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

13.15 *Abdomen:*

A. Generalized carcinomatosis; or

B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or

C. Ascites with demonstrated malignant cells.

13.16 *Esophagus or stomach:*

A. Carcinoma or sarcoma of the esophagus; or

B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or

C. Sarcoma of stomach not controlled by prescribed therapy; or

D. Inoperable carcinoma; or

E. Recurrence or metastases after resection.

13.17 *Small intestine:*

A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or

B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or

C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine* (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.

A. Unresectable; or

B. Metastases beyond the regional lymph nodes; or

C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

A. Primary or metastatic malignant tumors of the liver; or

B. Carcinoma of the gallbladder; or

C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

A. Carcinoma except islet cell carcinoma; or

B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

A. Unresectable; or

B. With hematogenous spread to distant sites; or

C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma.* With:

A. Infiltration beyond the bladder wall; or

B. Metastases to regional lymph nodes; or

C. Unresectable; or

D. Recurrence after total cystectomy; or

E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland*—carcinoma not controlled by prescribed therapy.

13.24 *Testicles:*

A. Choriocarcinoma; or

B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus*—carcinoma or sarcoma (corpus or cervix).

A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent after total hysterectomy; or

C. Total pelvic exenteration

13.26 *Ovaries*—all malignant, primary or recurrent tumors. With:

A. Ascites with demonstrated malignant cells; or

B. Unresectable infiltration; or

C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or

D. Distant metastases.

13.27 *Leukemia:* Evaluate under the criteria of 7.00ff, Hemic and Lymphatic Sytem.

13.28 *Uterine (Fallopian) tubes—carcinoma or sarcoma:*

A. Unresectable, or

B. Metastases to regional lymph nodes.

13.29 *Penis—carcinoma with metastases to regional lymph nodes.*

13.30 *Vulva—carcinoma, with distant metastases.*

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in Part A do not give appropriate consideration to the particular disease process in childhood).

Sec.

100.00 Growth Impairment.
101.00 Musculoskeletal System.
102.00 Special Senses and Speech.
103.00 Respiratory System.
104.00 Cardiovascular System.
105.00 Digestive System.
106.00 Genito-Urinary System.
107.00 Hemic and Lymphatic System.
108.00 [Reserved]
109.00 Endocrine System.
110.00 Multiple Body Systems.
111.00 Neurological.
112.00 Mental and Emotional Disorders.
113.00 Neoplastic Diseases, Malignant.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth

100.02 *Growth impairment,* considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment,* not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. *Rheumatoid arthritis.* Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases.* Vol. 23, 1972–1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the ''Joint Method of Measuring and Recording.'' published by the American Academy of Orthopedic Surgeons in 1965, or ''The Extremities and Back'' in *Guides to the Evaluation of Permanent Impairment,* Chicago, American Medical Association, 1971, Chapter 1, pp. 1–48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, collagen disorders septic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.01 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis.* With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

1. Limitation of motion of two major joints of 50 percent or greater; or

2. Fixed deformity of two major weight-bearing joints of 30 degrees or more; or

3. Radiographic changes of joint narrowing, erosion, or subluxation; or

4. Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine.*

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measuring 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or

drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 SPECIAL SENSES AND SPEECH

A. *Visual impairments in children.* Impairment of central visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description should be provided of the findings using other appropriate methods of examination, including a description of the techniques used for determining the central visual acuity for distance.

The accommodative reflex is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6–1969 (ANSI–1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in §102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 RESPIRATORY SYSTEM

A. *Documentation of pulmonary insufficiency.* The reports of spirometric studies for evaluation under Table I must be expressed in liters (BTPS). The reported FEV_1 should represent the largest of at least three satisfactory attempts. The appropriately labeled spirometric tracing of three FEV maneuvers must be submitted with the report, showing distance per second on the abscissa and distance per liter on the ordinate. The unit distance for volume on the tracing should be at least 15 mm. per liter and the paper speed at least 20 mm. per second. The height of the individual without shoes must be recorded.

The ventilatory function studies should not be performed during or soon after an acute episode or exacerbation of a respiratory illness. In the presence of acute bronchospasm, or where the FEV_1 is less than that stated in Table I, the studies should be repeated after the administration of a nebulized bronchodilator. If a bronchodilator was not used in such instances, the reason should be stated in the report.

A statement should be made as to the child's ability to understand directions and to cooperate in performance of the test, and should include an evaluation of the child's effort. When tests cannot be performed or completed, the reason (such as a child's young age) should be stated in the report.

B. *Cystic fibrosis.* This section discusses only the pulmonary manifestations of cystic fibrosis. Other manifestations, complications, or associated disease must be evaluated under the appropriate section.

The diagnosis of cystic fibrosis will be based upon appropriate history, physical examination, and pertinent laboratory findings. Confirmation based upon elevated concentration of sodium or chloride in the sweat should be included, with indication of the technique used for collection and analysis.

103.01 Category of Impairments, Respiratory

103.03 *Bronchial asthma.* With evidence of progression of the disease despite therapy and documented by one of the following:

A. Recent, recurrent intense asthmatic attacks requiring parenteral medication; or

B. Persistent prolonged expiration with wheezing between acute attacks and radiographic findings of peribronchial disease.

103.13 *Pulmonary manifestations of cystic fibrosis.* With:

A. FEV_1 equal to or less than the values specified in Table I (see §103.00A for requirements of ventilatory function testing); or

B. For children where ventilatory function testing cannot be performed:

1. History of dyspnea on mild exertion or chronic frequent productive cough; and

2. Persistent or recurrent abnormal breath sounds, bilateral rales or rhonchi; and

3. Radiographic findings of extensive disease with hyperaeration and bilateral peribronchial infiltration.

TABLE I

Height (in centimeters)	FEV_1 equal to or less than (L, BTPS)
110 or less	0.6
120	0.7
130	0.9
140	1.1
150	1.3
160	1.5
170 or more	1.6

104.00 CARDIOVASCULAR SYSTEM

A. *General.* Evaluation should be based upon history, physical findings, and appropriate laboratory data. Reported abnormalities should be consistent with the pathologic diagnosis. The actual electrocardiographic tracing, or an adequate marked photocopy, must be included. Reports of other pertinent studies necessary to substantiate the diagnosis or describe the severity of the impairment must also be included:

B. *Evaluation of cardiovascular impairment in children* requires two steps:

1. The delineation of a specific cardiovascular disturbance, either congenital or acquired. This may include arterial or venous disease, rhythm disturbance, or disease involving the valves, septa, myocardium or pericardium; and

2. Documentation of the severity of the impairment, with medically determinable and consistent cardiovascular signs, symptoms, and laboratory data. In cases where impairment characteristics are questionably secondary to the cardiovascular disturbance, additional documentation of the severity of the impairment (e.g., catheterization data, if performed) will be necessary.

C. *Chest roentgenogram* (6 ft. PA film) will be considered indicative of cardiomegaly if:

1. The cardiothoracic ratio is over 60 percent at age one year or less, or 55 percent at more than one year of age; or

2. The cardiac size is increased over 15 percent from any prior chest oentgenograms; or

3. Specific chamber or vessel enlargement is documented in accordance with established criteria.

D. *Tables I, II, and III* below are designed for case adjudication and not for diagnostic purposes. The adult criteria may be useful for older children and should be used when applicable.

E. *Rheumatic fever,* as used in this section assumes diagnosis made according to the revised Jones Criteria.

104.01 Category of Impairments, Cardiovascular

104.02 *Chronic congestive failure.* With two or more of the following signs:

A. Tachycardia (see Table I).

B. Tachypnea (see Table II).

C. Cardiomegaly on chest roentgenogram (see 104.00C).

D. Hepatomegaly (more than 2 cm. below the right costal margin in the right midclavicular line).

E. Evidence of pulmonary edema, such as rales or orthopnea.

F. Dependent edema.

G. Exercise intolerance manifested as labored respiration on mild exertion (e.g., in an infant, feeding).

TABLE I—TACHYCARDIA AT REST

Age	Apical Heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yr	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure for age (see Table III) and one of the following:

A. Impaired renal function as described under the criteria in 106.02; or

B. Cerebrovascular damage as described under the criteria in 111.06; or

C. Congestive heart failure as described under the criteria in 104.02.

TABLE III—ELEVATED BLOOD PRESSURE

Age	S (over) mm.	Diastolic (over) in mm.
Under 6 mo	95	60
6 mo. to 1 yr	110	70
1 through 8 yrs	115	80
9 through 11 yrs	120	80
12 through 15 yrs	130	80
Over 15 yrs	140	80

104.04 *Cyanotic congenital heart disease.*

With one of the following:

A. Surgery is limited to palliative measures; or

B. Characteristic squatting, hemoptysis, syncope, or hypercyanotic spells; or

C. Chronic hematocrit of 55 percent or greater or arterial O^2 saturation of less than 90 percent at rest, or arterial oxygen tension of less than 60 Torr at rest.

104.05 *Cardiac arrhythmia, such as persistent or recurrent heart block or A-V dissociation (with or without therapy).* And one of the following:

A. Cardiac syncope; or

B. Congestive heart failure as described under the criteria in 104.02; or

C. Exercise intolerance with labored respirations on mild exertion (e.g., in infants, feeding).

104.07 *Cardiac syncope* with at least one documented syncopal episode characteristic of specific cardiac disease (e.g., aortic stenosis).

104.08 *Recurrent hemoptysis.* Associated with either pulmonary hypertension or extensive bronchial collaterals due to documented chronic cardiovascular disease.

104.09 *Chronic rheumatic fever or rheumatic heart disease.* With:

A. Persistence of rheumatic fever activity for 6 months or more, with significant murmur(s), cardiomegaly (see 104.00C), and other abnormal laboratory findings (such as elevated sedimentation rate or electrocardiographic findings); or

B. Congestive heart failure as described under the criteria in 104.02.

105.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy, and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 Category of Impairments, Digestive

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable billiary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma, documentated by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).* And one of the following:

A. Stool fat excretion per 24 hours:

1. More than 15 percent in infants less than 6 months.

2. More than 10 percent in infants 6–18 months.

3. More than 6 percent in children more than 18 months; or

B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or

C. Serum carotene of 40 mcg./100 ml. or less; or

D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

1. History, physical examination, and laboratory evidence of renal disease.

2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 Category of Impairments, Genito-Urinary

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73 m^2 of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 Nephrotic syndrome, with edema not controlled by prescribed therapy. And:

A. Serum albumin less than 2 gm./100 ml.; or

B. Proteinuria more than 2.5 gm./1.73m^2/day.

107.00 HEMIC AND LYMPHATIC SYSTEM

A. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic

107.03 *Hemolytic anemia (due to any cause).* Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, and reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease.* With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder.* With:

A. Repeated spontaneous or inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia.* Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability.* Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth.* Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation.* Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endrocrine

109.02 *Thyroid Disorders.*

A. Hyperthyroidism (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T_4) and either elevated free T_4 or resin T_3 uptake; or

2. Elevated thyroid uptake of radioiodine; or

3. Elevated serum triiodothyronine (T_3).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 69 or less; or

2. Growth impairment as described under the criteria in 100.02 A and B; or

3. Precocious puberty.

109.03 *Hyperparathyroidism (as documented in 109.00C).* With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism or Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalmic thirst center, with chronic or recurrent hypernatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hyroxycorticosteroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency (as documented in 109.00 C and E)* with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus (as documented in 109.00C) requiring parenteral insulin.* And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 *Iatrogenic hypercorticoid state.*

With chronic glucocorticoid therapy resulting in one of the following:

A. Osteoporosis; or

B. Growth retardation as described under the criteria in 100.02 A or B; or

C. Diabetes mellitus as described under the criteria in 109.08; or

D. Myopathy as described under the criteria in 111.06; or

E. Emotional disorder as described under the criteria in 112.00ff.

109.10 *Pituitary dwarfism (with documented growth hormone deficiency).* And growth impairment as described under the criteria in 100.02B.

109.11 *Adrenogenital syndrome.* With:

A. Recent, recurrent self-losing episodes despite prescribed therapy; or

B. Inadequate replacement therapy manifested by accelerated bone age and virilization, or

C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 *Hypoglycemia (as documented in 109.00C)*. With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 *Gonadal Dysgenesis (Turner's Syndrome), chromosomally proven*. Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 MULTIPLE BODY SYSTEMS

A. *Catastrophic congenital abnormalities or disease*. This section refers only to very serious congenital disorders, diagnosed in the newborn or infant child.

B. *Immune deficiency diseases*. Documentation of immune deficiency disease must be submitted, and may include quantitative immunoglobulins, skin tests for delayed hypersensitivity, lymphocyte stimulative tests, and measurements of cellular immunity mediators.

110.01 Category of Impairments, Multiple Body Systems

110.08 *Catastrophic congenital abnormalities or disease*. With:

A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or

B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

110.09 *Immune deficiency disease*.

A. *Hypogammaglobulinemia or dysgammaglobulinemia*. With:

1. Recent, recurrent severe infections; or

2. A complication such as growth retardation, chronic lung disease, collagen disorder, or tumors.

E. *Thymic dysplastic syndromes* (such as Swiss, diGeorge).

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequency of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure disorder be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of seizures when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, a seizure disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that seizures have persisted more than three months after prescribed therapy began.

B. *Minor motor seizures*. Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction*. As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurologic abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), wherever applicable.

D. *Impairment of communication*. The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effective communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 *Major motor seizure disorder*.

A. *Major motor seizures*. In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or

2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures*. In a child with an established seizure disorder, the occurrence of a least one major motor seizure in the year prior to application despite at least three months of prescribed treatment. And one of the following:

1. IQ of 69 or less; or

2. Significant interference with communication due to speech, hearing, or visual defect; or

3. Significant emotional disorder; or

4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizure disorder*. In a child with an established seizure disorder, the occurrence of more than one minor

motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 *Brain tumors. A. Malignant* gliomas (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas; or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 *Motor dysfunction (due to any neurological disorder).* Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

A. Fine and gross movements; or

B. Gait and station.

111.07 *Cerebral palsy*. With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

1. IQ of 69 or less; or

2. Seizure disorder, with at least one major motor seizure in the year prior to application; or

3. Significant interference with communication due to speech, hearing or visual defect; or

4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders).* With one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of §101.03 or §111.06; or

B. Less severe motor dysfunction (but more than slight), and:

1. Urinary or fecal incontinence when inappropriate for age; or

2. IQ of 69 or less; or

C. Four extremity involvement; or

D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder*. And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 MENTAL AND EMOTIONAL DISORDERS

A. *Introduction*. This section is intended primarily to describe mental and emotional disorders of young children. The criteria describing medically determinable impairments in adults should be used where they clearly appear to be more appropriate.

B. *Mental retardation. General.* As with any other impairment, the necessary evidence consists of symptoms, signs, and laboratory findings which provide medically demonstrable evidence of impairment severity. Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not clearly covered under the provisions of 112.05A. Developmental milestone criteria may be the sole basis for adjudication only in cases where the child's young age and/or condition preclude formal standardized testing by a psychologist or psychiatrist experienced in testing children.

Measures of intellectual functioning. Standardized intelligence tests, such as the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), the Wechsler Intelligence Scale for Children—Revised (WISC-R), the Revised Stanford-Binet Scale, and the McCarthey Scales of Children's Abilities, should be used wherever possible. Key data such as subtest scores should also be included in the report. Tests should be administered by a qualified and experienced psychologist or psychiatrist, and any discrepancies between formal tests results and the child's customary behavior and daily activities should be duly noted and resolved.

Developmental milestone criteria. In the event that a child's young age and/or condition preclude formal testing by a psychologist or psychiatrist experienced in testing children, a comprehensive evaluation covering the full range of developmental activities should be performed. This should consist of a detailed account of the child's daily activities together with direct observations by a professional person; the latter should include indices or manifestations of social, intellectual, adaptive, verbal, motor (posture, locomotion, manipulation), language, emotional, and self-care development for age. The above should then be related by the evaluating or treating physician to established developmental norms of the kind found in any widely used standard pediatrics text.

c. *Profound combined mental-neurological-musculoskeletal impairments*. There are children with profound and irreversible brain damage resulting in total incapacitation. Such children may meet criteria in either neurological, musculoskeletal, and/or mental sections; they should be adjudicated under the criteria most completey substantiated by the medical evidence submitted. Frequently, the most appropriate criteria will be found under the mental impairment section.

112.01 Category of Impairments, Mental and Emotional

112.02 *Chronic brain syndrome*. With arrest of developmental progression for at least six months or loss of previously acquired abilities.

112.03 *Psychosis of infancy and childhood.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities; constriction of age-appropriate interests; deficiency of age-approrpiate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

A. Significant withdrawal or detachment; or

B. Impaired sense of reality; or

C. Bizarre behavior patterns; or

D. Strong need for maintenance of sameness, with intense anxiety, fear, or anger when change is introduced; or

E. Panic at threat of separation from parent.

112.04 *Functional nonpsychotic disorders.* Documented by psychiatric evaluation and supported, if necessary, by the results of appropriate standardized psychological tests and manifested by marked restriction in the performance of daily age-appropriate activities; constriction of age-appropriate interests; deficiency of age-appropriate self-care skills; and impaired ability to relate to others; together with persistence of one (or more) of the following:

A. Psychophysiological disorder (e.g., diarrhea, asthma); or

B. Anxiety; or

C. Depression; or

D. Phobic, obsessive, or compulsive behavior; or

E. Hypochondriasis; or

F. Hysteria; or

G. Asocial or antisocial behavior.

112.05 *Mental retardation.*

A. Achievement of only those developmental milestones generally acquired by children no more than one-half the child's chronological age; or

B. IQ of 59 or less; or

C. IQ of 60–69, inclusive, and a physical or other mental impairment imposing additional and significant restriction of function or developmental progression.

113.00 NEOPLASTIC DISEASES, MALIGNANT

A. *Introduction.* Determination of disability in the growing and developing child with a malignant neoplastic disease is based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and

2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation.* The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors,* as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 *Lymphoreticular malignant neoplasms.*

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or

2. For 2½ years from time of recurrence of active disease.

113.03 *Malignant solid tumors.* Consider under a diability:

A. For 2 years from the time of initial diagnosis; or

B. For 2 years from the time of recurrence of active disease.

113.04 *Neuroblastoma.* With one of the following:

A. Extension across the midline; or

B. Distant metastases; or

C. Recurrence; or

D. Onset at age 1 year or older.

113.05 *Retinoblastoma.* With one of the following:

A. Bilateral involvement; or

B. Metastases; or

C. Extension beyond the orbit; or

D. Recurrence.

APPENDIX 2 TO PART 220—MEDICAL-VOCATIONAL GUIDELINES

Sec.

200.00 Introduction.
201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

200.00 *Introduction.* (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the ''Decisions'' shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the ''Dictionary of Occupational Titles'' and the ''Occupational Outlook Handbook,'' published by the Department of Labor; the ''County Business Patterns'' and ''Census Surveys'' published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (*i.e.*, the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience must first be determined. When assessing the person's residual functional capacity, the Board considers his or her symptoms (such as pain), signs, and laboratory findings together with other evidence the Board obtains.

(d) The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other,

nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 *Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).* (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g., has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50–54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no

longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h) The term ''younger individual'' is used to denote an individual age 18 through 49. For those within this group who are age 45–49, age is a less positive factor than for those who are age 18–44. Accordingly, for such individuals; (1) who are restricted to sedentary work, (2) who are unskilled or have no transferable skills, (3) who have no relevant past work or who can no longer perform vocationally relevant past work, and (4) who are either illiterate or unable to communicate in the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative: Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of a severe medically determinable cardiovascular impairment (which does not meet or equal the listings in appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate. Example 2: An illiterate 41 year old individual with mild mental retardation (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do not specifically meet any of the rules in appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

(i) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18–44 even if they are illiterate or unable to communicate in English.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less	Unskilled or none	Disabled.
201.02	do	do	Skilled or semiskilled—skills not transferable [1].	Do.
201.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
201.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
201.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
201.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Disabled.
201.07	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.08	.....do	High school graduate or more—provides for direct entry into skilled work[2].	Skilled or semiskilled—skills not transferable[1].	Do.
201.09	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled.
201.10	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
201.11	.....do	.....do	Skilled or semiskilled—skills transferable.	Not disabled.
201.12	.....do	High school graduate or more—does not provide for direct entry into skilled work[3].	Unskilled or none	Disabled.
201.13	.....do	High school graduate or more—provides for direct entry into skilled work[3].	.....do	Not disabled.
201.14	.....do	High school graduate or more—does not provide for direct entry into skilled work[3].	Skilled or semiskilled—skills not transferable.	Disabled.
201.15	.....do	.....do	Skilled or semiskilled—skills transferable.	Not disabled.
201.16	.....do	High school graduate or more—provides for direct entry into skilled work[3].	Skilled or semiskilled—skills not transferable.	Do.
201.17	Younger individual age 45–49.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
201.18	.....do	Limited or less—at least literate and able to communicate in English.	.....do	Not disabled.
201.19	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
201.21	.....do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
201.23	Younger individual age 18–44.	Illiterate or unable to communicate in English.	Unskilled or none	Do.[4]
201.24	.....do	Limited or less—at least literate and able to communicate in English.	.....do	Do.[4]
201.25	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.[4]
201.26	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]
201.27	.....do	High school graduate or more	Unskilled or none	Do.[4]
201.28	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.[4]
201.29	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]

[1] See 201.00(f).
[2] See 201.00(d).
[3] See 201.00(g).
[4] See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial

numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (i.e., closely approaching advanced age, 50–54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60–64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18–49) even if illiterate or unable to communicate in English.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.
202.02	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
202.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
202.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
202.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	do	do	Skilled or semiskilled—skills transferable [2].	Not disabled.
202.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
202.10	do	Limited or less—At least literate and able to communicate in English.	do	Not disabled.
202.11	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
202.12	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.13	.....do	High school graduate or more	Unskilled or none	Do.
202.14	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.15	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate or unable to communicate in English.	Unskilled or none	Do.
202.17	.....do	Limited or less—At least literate and able to communicate in English.	.....do	Do.
202.18	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
202.20	.....do	High school graduate or more	Unskilled or none	Do.
202.21	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
202.22	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.

[1] See 202.00(f).
[2] See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impair- ment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience (i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s), may still be found disabled even though the individual is able to do medium work.

(c) However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60–64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or none	Unskilled or none	Disabled.
203.02	.....do	Limited or less	None	Do.
203.03	.....do	Limited	Unskilled	Not disabled.
203.04	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.06	.....do	High school graduate or more	Unskilled or none	Do.
203.07	.....do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.08	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.09	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	.....do	.....do	Unskilled	Not disabled.
203.12	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
203.13	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.14	.....do	High school graduate or more	Unskilled or none	Do.
203.15	.....do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.17	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
203.20	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.21	.....do	High school graduate or more	Unskilled or none	Do.
203.22	.....do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.24	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.
203.27	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.28	.....do	High school graduate or more	Unskilled or none	Do.
203.29	.....do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.
203.31	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of ''not disabled''. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[56 FR 12980, Mar. 28, 1991, as amended at 68 FR 60294, Oct. 22, 2003]

APPENDIX 3 TO PART 220—RAILROAD RETIREMENT BOARD OCCUPATIONAL DISABILITY STANDARDS

1. INTRODUCTION

1.01 The Board uses this appendix to adjudicate the occupational disability claims of employees with medical conditions and job titles covered by the Tables in this appendix. The Tables are divided into ''Body Parts'', with each Body Part further divided by job title. Under each job title there is a list of impairments and tests with accompanying test results which establish a finding of ''D'' (disabled). The use of these Tables is a three-step process. In the first step we determine whether the employee's regular railroad occupation is covered by the Tables; next we establish the existence of an impairment covered by the Tables; finally, we reach a disability determination. If we do not find an employee disabled under these Tables, the employee may still be found disabled using Independent Case Evaluation (ICE), as explained in subpart C of this part.

1.02 The Cancer Tables are treated in a different way than other body systems. Different types of cancer and their treatments have different functional impacts. In the Cancer Tables the impact of the impairment is seen as being significant or not significant. Therefore, these tables contain an ''S'' (significant) which is equivalent to a ''D'' rating. A detailed explanation of how to use those tables is in that section. The steps to use the remaining Tables are explained below:

2. CONFIRMING THE IMPAIRMENT

2.01 Once we determine that the employee's regular railroad occupation is covered by the Job Titles in the Tables, we must determine the existence of an impairment covered by the Tables. This is done through the use of Confirmatory Tests. These tests can include information from medical records, surgical or operative reports, or specific diagnostic test results. Confirmatory Tests are listed in the initial section regarding each Body Part covered in the Tables. If an impairment cannot be confirmed because of inconsistent medical information, ICE may be required.

2.02 There are two types of Confirmatory Tests as follows.

2.03 ''Highly Recommended'' Tests—The designation of a confirmatory test as being ''highly recommended'' means that the test is almost always performed to confirm the existence of the impairment. For many conditions, only one ''highly recommended'' test finding is suggested to confirm the impairment. However, there may be times when that test is not available or is negative, but other more detailed testing confirms the impairment.

2.04 *Example A:* To confirm the condition of pulmonary hypertension, the Tables under Body Part C., Cardiac, designate as ''highly recommended'': an electrocardiogram which indicates definite right ventricular hypertrophy. However, the impairment may also be confirmed by insertion of a Swan-Ganz catheter into the pulmonary artery and the pulmonary artery pressure measured directly.

2.05 There may be some conditions for which several ''highly recommended'' tests are suggested to confirm an impairment. In these circumstances, we will use all ''highly recommended'' tests to establish the existence of the impairment.

2.06 *Example B:* Under Body Part E., Lumbar Sacral Spine, three highly recommended medical findings are identified for the diagnosis of chronic back pain, not otherwise specified. These findings include:

A. A history of back pain under medical treatment for at least one year, and

B. A history of back pain unresponsive to therapy for at least one year, and

C. A history of back pain with functional limitations for at least one year.

2.07 All three of these criteria must be satisfied to confirm the existence of chronic back pain.

2.08 Sometimes the employee may have undergone detailed testing which is as reliable as one of the ''highly recommended'' tests listed in the Tables. In cases where an impairment has not been confirmed by one of the designated ''highly recommended'' tests, the impairment may still be confirmed by ''recommended'' tests (see below) or by evidence acceptable under section 220.27 of this part.

2.09 Recommended Tests—The designation of a confirmatory test as ''recommended'' means that the test need not be performed, or be positive, to confirm the impairment. However, a positive test provides significant support for confirming the impairment. If there are no ''highly recommended'' tests for confirming the impairment, at least one of the ''recommended'' tests should be positive.

2.10 There are two categories of recommended tests which are described below.

A. *Imaging studies*—These studies can include MRI, CAT scan, myelogram, or plain film x-rays. For conditions where several of these imaging studies are identified as ''recommended'' tests, at least one of the test results should be positive and meet the confirmatory test criteria. For some conditions, such as degenerative disc condition, there are several equivalent imaging methods to confirm a diagnosis.

B. *Other tests*—This category of tests refers to non-imaging studies.

2.11 If there are no ''highly recommended'' confirmatory tests designated to confirm an impairment and the ''recommended'' confirmatory tests only include non-imaging

procedures, at least one of these tests should be positive to confirm the impairment. The greater the number of tests that are positive, the greater the confidence that the correct diagnosis has been established.

2.12 *Example:* Under Body Part C., Cardiac, the diagnostic confirmatory tests for ventricular ectopy, a cardiac arrhythmia, include the following ''recommended'' tests:

A. Medical record review, i.e., a review of the claimant's medical records, or

B. Holter monitoring, or

C. Provocative testing producing a definite arrhythmia.

2.13 In this situation, only one of the ''recommended'' confirmatory tests need be positive to confirm the impairment. However, the more tests that are positive, the stronger the support for the diagnosis.

2.14 In no circumstance will the Board require that an invasive test be performed to confirm an impairment. Several of the Confirmatory Tests which are described in the Tables are invasive and it is not the intention of the Board to suggest that these be performed. The inclusion of invasive tests in the Tables Confirmatory Tests section is intended to help the Board evaluate the significance of findings from such tests that may have already been performed and which are part of the submitted medical record.

2.15 If an employee's impairment(s) cannot be confirmed by use of the confirmatory tests listed in the Tables, it still may be confirmed by medical evidence described in section 220.27 of this part. However, if a claimant's impairment(s) cannot be confirmed through use of the Tables or under section 220.27, and the medical evidence is complete and in concordance, the claimant will be found not disabled.

3. Disability Determination

3.01 Once the Board determines that the employee's regular railroad occupation is covered by one of the Job Titles in the Tables and that his or her alleged impairment fits into a Body Part covered by the Tables and can be confirmed, we examine the results of any of the disability tests listed under the impairment. If the results from any of these tests indicate a ''D'' finding, the employee is found disabled. If none of the test results indicate a ''D'' finding, then the employee's claim is evaluated using ICE.

3.02 *Example:* A trainman has angina as confirmed by the recommended tests under Body Part A: Cardiac—Angina. An echocardiogram shows that he has poor ejection fraction ≤35%. The employee is rated disabled. If none of the results of the listed disability tests match the results required for a ''D'' finding, then the employee's claim is evaluated under ICE.

Tables

A. Cancer
B. Endocrine
C. Cardiac
D. Respiratory
E. Lumbar Sacral Spine
F. Cervical Spine
G. Shoulder and Elbow
H. Hand and Arm
I. Hip
J. Knee
K. Ankle and Foot

A. Cancer

Cancer

Cancer conditions can be viewed as belonging to one of three categories.

Category 1: Significant impact on functional capacity or anticipated life span.

Category 2: Intermediate impact on functional capacity; large individual variability.

Category 3: No significant impact on functional capacity or expected life span.

The factors that are considered in developing these categories include the following:

Type of Cancer

The functional impact of different malignancies varies tremendously and each malignancy has to be considered on an individual basis.

Magnitude of Disease

The disability standards are based upon the magnitude or extent of disease. The extent of disease affects both anticipated life span and the functional capacity or work ability of the individual. Localized cancer including cancer ''in situ'' can frequently be completely cured and not have an impact on functional capacity or life span. In contrast, many cancers that have distant or significant regional spread generally have a poor prognosis. The magnitude or extent of disease is classified into three categories: local, regional and distant.

The criteria which are used to classify a cancer into one of the three categories are based upon the distillation of several staging methods into a single system [Miller, et al. (1992). Cancer Statistics Review, 1973–1989; NIH Publication No. 92–2789].

Effects of Treatment

Although some types of cancer may be potentially curable with radical surgery and/or radiation therapy, the treatment regimen may result in a significant impairment that could affect functional capacity and ability to work. For example, a person with a laryngeal tumor which had spread regionally could be cured by a complete laryngectomy and radiotherapy. However, this treatment

could result in a loss of speech and significantly impair the individual's communicative skills or ability to use certain types of respiratory protective equipment.

Prognosis

Some cancers may have minimal impact on a person's functional capacity, but have a very poor prognosis with respect to life expectancy. For example, an individual with early stage brain cancer may be minimally impaired, but have a poor prognosis and minimal potential for surviving longer than two years. Five and two year survival data are presented in the Cancer Disability Guideline Table which follows.

The Cancer Disability Guideline Table provides information concerning the probability of survival for five years for local, regional, and distant disease for each type of malignancy. In addition, two-year survival data are also presented for all disease stages. The five-year survival data are based upon data collected from population-based registries in Connecticut, New Mexico, Utah, Hawaii, Atlanta, Detroit, Seattle and the San Francisco and East Bay area between 1983 and 1987 (Miller, 1992). The two-year data are from a cohort study initially diagnosed in 1988.

Assessment

The malignancies are classified as disabling (Category 1), potentially disabling (Category 2) and non-disabling (Category 3). Category 2 conditions must be evaluated with respect to how the worker's tumor affects the worker's ability to perform the job and an assessment of his life span.

Information concerning the potential impact of the malignancy on a worker's ability to perform a job is identified in the Functional Impact column in the table. All railroad occupations in the Tables are considered together. Functional impacts are classified as significant if the treatment or sequelae from treatment including radiotherapy, chemotherapy and/or surgery is likely to impair the worker from performing the job. If the treatment results in a significant impairment of another organ system, the individual should be evaluated for disability associated with impairment of that body part. For example, a person undergoing an amputation for a bone malignancy would have to be evaluated for an amputation of that body part. For many cancers, it is difficult to make generalizations regarding the level of impairment that will occur after the person has initiated or completed treatment. Nonsignificant impacts include those that are unlikely to have any effect on the individual's work capacity.

Cancer type	2-year[1]	5-year[1]	Disability status[2]	Functional impact[3]
Brain:				
Local		26	1	S
Regional		27.9	1	S
Distant		23.6	1	S
Female Breast:				
Regional		71.1	2	S
Distant		17.8	1	S
Colon:				
Local		91	2	S
Regional		60.1	2	S
Distant		6	1	S
Rectal:				
Local		84.5	2	S
Regional		50.7	2	S
Distant		5.3	1	S
Esophagus:				
Local		18.5	1	S
Regional		5.2	1	S
Distant		1.8	1	S
Hodgkin's Disease:[4]				
Stage 1		90–95	3	S
Stage 2		86	2	S
Stage 3		<80	2	S
Stage 4		<80	1	S
Kidney/Renal Pelvis:				
Local		85.4	3	S
Regional		56.3	2	S
Distant		9	1	S
Larynx:				
Local		84.2	2	S
Regional		52.5	2	S
Distant		24	1	S
Acute Lymphocytic Leukemia:				
All		51.1	2	S
Chronic Lymphocytic Leukemia:				
All		66.2	2	S

Cancer type	2-year[1]	5-year[1]	Disability status[2]	Functional impact[3]
Acute Myelogenous Leukemia:				
All		9.7	1	S
Chronic Myelogenous Leukemia:				
All		21.7	1	S
Liver/Intrahepatic Bile Duct:				
Local		15.1	1	S
Regional		5.8	1	S
Distant		1.9	1	S
Lung/Bronchus:[5]				
Local		45.6	2	S
Regional		13.1	1	S
Distant		1.3	1	S
Melanomas of Skin:				
Regional		53.6	2	S
Distant		12.8	1	S
Oral Cavity/Pharyngeal:				
Local		76.2	2	S
Regional		40.9	2	S
Distant		18.7	1	S
Pancreas:				
Local		6.1	1	S
Regional		3.7	1	S
Distant		1.4	1	S
Prostate:				
Local		91	3	S
Regional		80.4	2	S
Distant		28	1	S
Stomach:				
Local		55.4	1	S
Regional		17.3	1	S
Distant		2.1	1	S
Testicular:				
Distant		65.5	1	S
Thyroid:				
Regional		93.1	3	S
Distant		47.2	1	S
Bladder:				
Regional		46	2	S
Distant		9.1	1	S

[1]Source of 2 and 5 year survival data: Miller BA et al. Cancer Statistics Review 1973–1989. NIH Publication No. 92–2789.
[2]Disability Status:
Category 1: Significant impact on functional capacity or life span.
Category 2: Intermediate impact.
Category 3: No significant impact on functional capacity or life span.
[3]Functional Impacts:
(S) Significant—significant potential for the effects of treatment (radiotheraphy, chemotherapy. surgery) to affect functional capacity.
[4]Hodgkin's disease data presented for each stage derived from American Cancer Society. American Cancer Society Textbook reference for unstaged cancer is derived from Cancer Statistics Review (See 3). In addition to other data, see: American Cancer Society Textbook of Clinical Oncology. Eds: Holleb AI, Fink DJ, Murphy GP, Atlanta: American Cancer Society, Inc. 1991.)
[5]Small cell carcinoma is classified as a 1.

B. Endocrine

Confirmatory test	Minimum result	Requirements
BODY PART: ENDOCRINE CONFIRMATORY TESTS		
Diabetes, requiring insulin (IDDM): Medical record review	Confirmation of condition and need for insulin use.	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: ENDOCRINE JOB TITLE: ENGINEER		
Diabetes, requiring insulin (IDDM): Medical record review	Confirmation of condition and need for insulin use.	D

C. Cardiac

Confirmatory test	Minimum result	Requirements
BODY PART: CARDIAC CONFIRMATORY TESTS		
Angina:		
Medical record review	Confirmed history of ischemia including copies of electrocardiogram.	Recommended.
Stress test	Definite ischemia on exercise test	Recommended.
Thallium study	Definite ischemia with exercise	Recommended.
Aortic valve disease:		
Cardiac catheterization	Proven and significant	Recommended.
Echocardiogram	Significant valve disease	Recommended.
Coronary artery disease:		
Medical record review	Documented ischemia with electrocardiogram confirmation.	Recommended.
Medical record review	Documented myocardial infarction	Recommended.
Stress test	Positive	Recommended.
Thallium study	Definite ischemia with exercise	Recommended.
Angiography	Definite occlusion (≤60%) of one vessel	Recommended.
Cardiomyopathy:		
Echocardiogram	Proven ejection fraction ≤35%	Recommended.
Catheterization	Poor global function and not coronary artery disease.	Recommended.
Hypertension:		
Medical record review	Documentation of hypertension for one year.	Highly recommended.
Medical record review	Definite diagnosis by cardiologist or internist.	Highly recommended.
Medical record review	Confirmation of medication use	Highly recommended.
Arrhythmia: heart block:		
Medical record review	Proven episode with electrocardiogram confirmation.	Recommended.
Electrocardiogram	Documentation of arrhythmia	Recommended.
Mitral valve disease:		
Cardiac catheterization	Significant valve disease	Recommended.
Echocardiogram	Significant valve disease	Recommended.
Pericardial disease:		
Medical record review	Confirmed by cardiologist or internist	Highly recommended.
Pulmonary hypertension:		
Physical examination	Increased pulmonic sound or pulmonary ejection murmur by cardiologist or internist.	Recommended.
Electrocardiogram	Definite right ventricular hypertension	Highly recommended.
Ventricular ectopy:		
Medical record review	Definite episode within one year	Recommended.
Holter monitoring	Definite arrhythmia	Recommended.
Provocative testing	Positive response	Recommended.
Arrhythmia: supraventricular tachycardia:		
Medical record review	Definite episode within one year	Recommended.
Holter monitoring	Definite arrhythmia	Recommended.
Post heart transplant:		
Medical record review	Documented	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: CARDIAC JOB TITLE: TRAINMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D

Disability test	Test result	Disability classification
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤ 7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤ 7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: ENGINEER		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D

Disability test	Test result	Disability classification
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: DISPATCHER		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D

Disability test	Test result	Disability classification
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: CARMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤ 5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤ 5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: SIGNALMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infractions	D

Disability test	Test result	Disability classification
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catherization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: TRACKMAN		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤7 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤7 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤7 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D

Disability test	Test result	Disability classification
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥5 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤7 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: MACHINIST		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D

Disability test	Test result	Disability classification
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D

BODY PART: CARDIAC
JOB TITLE: SHOP LABORER

Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG.	
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg.	
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D

BODY PART: CARDIAC
JOB TITLE: SALES REPRESENTATIVE

Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D

Disability test	Test result	Disability classification
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Hypertension:		
Medical record review	Diastolic ≤120 and systolic ≤160, 50% of the time and evidence of end organ damage (blood creatinine ≤2; urinary protein ≤½ gm; or EKG evidence of ischemia).	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D
BODY PART: CARDIAC JOB TITLE: GENERAL OFFICE CLERK		
Angina:		
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by cardiologist	D
Stress test	Documented hypotensive response	D
Stress test: significant ST changes	Definite ischemia ≤5 METS	D
Aortic valve disease:		
Cardiac catheterization	Aortic gradient 25–50 mm HG	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Coronary artery disease:		
Myocardial infarction	Multiple infarctions	D
Echocardiogram	Confirmed ventricular aneurysm	D
Cardiac catheterization	Aortic gradient 25–50 mm Hg	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Medical record review	Unstable as diagnosed by a Cardiologist	D
Stress test	Documented hypotensive response	D
Stress test	Definite ischemia ≤5 METS	D
Isotope, e.g., thallium study	Definite ischemia ≤5 METS	D
Cardiomyopathy:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Arrhythmia: heart block:		
Holter	Documented asystole length ≤1.5–2 seconds.	D

Disability test	Test result	Disability classification
Medical record review	Documented syncope with proven arrhythmia.	D
Mitral valve disease:		
Cardiac catheterization	Mitral valve gradient ≥10 mm Hg	D
Cardiac catheterization	Mitral regurgitation severe	D
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Stress test	Peak exercise ≤5 METS	D
Pericardial disease:		
Cardiac catheterization	Poor ejection fraction ≤35%	D
Echocardiogram	Poor ejection fraction ≤35%	D
Ventricular ectopy:		
Medical record review	Documented life threatening arrhythmia	D
Holter	Uncontrolled ventricular rhythm	D
Medical record review	Documented related syncope	D
Arrhythmia: supraventricular tachycardia:		
Medical record review	Documented related syncope	D
Post heart transplant:		
Medical record review	Post heart transplant	D

D. Respiratory

Confirmatory test	Minimum result	Requirements
BODY PART: RESPIRATORY CONFIRMATORY TESTS		
Asthma:		
Spirometry	FEV1/FVC ratio diminished	Recommended.
Spirometry	≤15% change with administration of bronchodilator.	Recommended.
Methacholine challenge test	Positive: FEV1 decrease ≤20% at (PC <=8 mg/ml).	Recommended
Bronchiectasis:		
Medical record review	Chronic cough and sputum	Recommended.
Chest X-ray	Bronchiectasis demonstrated	Recommended.
Chest CAT scan	Bronchiectasis demonstrated	Recommended.
Chronic bronchitis:		
Medical record review	Frequent cough—2 years duration	Highly recommended.
Chronic obstructive pulmonary disease:		
Spirometry	FEV1/FVC ratio below 65% when stable	Highly recommended.
Spirometry	FEV1 below 75% of predicted when stable	Highly recommended.
Cor pulmonale:		
Electrocardiogram	Definite right ventricular hypertrophy	Recommended.
Echocardiogram	Definite right ventricular hypertrophy	Recommended.
Pulmonary fibrosis:		
Lung biopsy	Diffuse fibrosis	Recommended.
Chest CAT scan	More than minimal fibrosis	Recommended.
Lung resection:		
Medical record review	At least one lobe resected	Highly recommended.
Pneumothorax:		
Medical record review	Required hospitalization with chest tube drainage.	Highly recommended.
Restrictive lung disease:		
Chest X-ray	Restrictive lung changes	Recommended.
DLCO	Abnormal	Highly recommended.
Chest CAT scan	Restrictive lung changes	Recommended.
Spirometry	FVC <75% predicted	Highly recommended.
Silicosis:		
Medical record review	Occupational exposure for at least 1 year	Highly recommended.
Tuberculosis:		
Chest X-ray	Evidence of changes consistent with tuberculosis infection.	Recommended.
Culture	Positive	Recommended.

Disability test	Test result	Disability classification
BODY PART: RESPIRATORY		
JOB TITLE: TRAINMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	

Disability test	Test result	Disability classification
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	efinite positive right ventricular hypertrophy	D
Silicosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg If stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: CARMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

Disability test	Test result	Disability classification
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: SIGNALMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D

Disability test	Test result	Disability classification
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting AGB	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: TRACKMAN		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D

Disability test	Test result	Disability classification
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: MACHINIST		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting AGB	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
BODY PART: RESPIRATORY JOB TITLE: SHOP LABORER		
Asthma:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Bronchiectasis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

Disability test	Test result	Disability classification
Chronic bronchitis:		
Spirometry	Repeated spirometry FEV1 <40% over a 12 month period.	D
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Chronic obstructive pulmonary disease (COPD):		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Cor pulmonale:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Pulmonary fibrosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Lung resection:		
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Restrictive lung disease:		
DLCO	<45% predicted	D
Pulmonary exercise test or exercise ABG.	PO2 drop ≤5 torr at maximum exercise	D
Pulmonary exercise test	Maximum VO2 <15 ml/kg	D
Spirometry	FVC <50% predicted	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D
Silicosis:		
Resting ABG	PCO2 arterial ≤50 mm Hg if stable	D
Electrocardiogram	Definite positive right ventricular hypertrophy.	D

E. Lumbar Sacral Spine

Confirmatory test	Minimum result	Requirements
BODY PART: LS SPINE CONFIRMATORY TESTS		
Ankylosing spondylitis:		
X-ray-lumbar sacral spine	Sacroilitis	Highly recommended.
HLA B27 (blood test)	Positive HLA B27 (90% case)	Recommended.
Backache, unspecified:		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Chronic back pain, not otherwise specified:.		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Cauda equina syndrome with bowel or bladder dysfunction:.		
Magnetic resonance imaging	Neural impingement of spinal nerves below L1.	Recommended.

E. Lumbar Sacral Spine—Continued

Confirmatory test	Minimum result	Requirements
Computerized tomography	Neural impingement of spinal nerves below L1.	Recommended.
Cystometrogram	Impaired bladder function	Recommended.
Rectal examination	Diminished rectal sphincter tone	Recommended.
Myelogram	Neural impingement of spinal nerves below L1.	Recommended.
Degeneration of lumbar disc:		
X-ray lumbar sacral spine	Significant degenerative disc changes	Recommended.
Computerized tomography	Significant degenerative disc changes	Recommended.
Magnetic resonance imaging	Significant degenerative disc changes	Recommended.
Myelogram	Significant degenerative disc changes	Recommended.
Displacement of lumbar disc:.		
X-ray-lumbar sacral spine	Significant degenerative disc changes	Recommended.
Computerized tomography	Significant degenerative disc changes	Recommended.
Magnetic resonance imaging	Significant degenerative disc changes	Recommended.
Myelogram	Significant degenerative disc changes	Recommended.
Fracture: vertebral body:.		
Magnetic resonance imaging	Fracture vertebral body	Recommended.
Computerized tomography	Fracture vertebral body	Recommended.
X-ray-lumbar sacral spine	Fracture vertebral body	ommended.
Fracture: posterior element with spinal canal displacement:		
Magnetic resonance imaging	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
Computerized tomography	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
X-ray-lumbar sacral spine	Fracture posterior spinal element with displacement of spinal canal.	Recommended.
Fracture: posterior spinal element with no displacement:.		
X-ray-lumbar sacral spine	Fracture posterior spinal element	Recommended.
Magnetic resonance imaging	Fracture posterior spinal element	Recommended.
Computerized tomography	Fracture posterior spinal element	Recommended.
Fracture: spinous process:		
X-ray-lumbar sacral spine	Spinous process fracture	Recommended.
Magnetic resonance imaging	Spinous process fracture	Recommended.
Computerized tomography	Spinous process fracture	Recommended.
Fracture: Transverse process:		
Lumbar sacral spine	Transverse process fracture	Recommended.
Magnetic resonance imaging	Transverse process fracture	Recommended.
Computerized tomography	Transverse process fracture	Recommended.
Intervertebral disc disorder:		
X-ray-lumbar sacral spine	Significant disc degeneration	Recommended.
Magnetic resonance imaging	Significant disc degeneration	Recommended.
Computerized tomography	Significant disc degeneration	Recommended.
Myelogram	Significant disc degeneration	Recommended.
Lumbago:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Lumbosacral neuritis:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical history	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Lumbar spinal stenosis:		
Computerized tomography	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.
Magnetic resonance imaging	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.
Myelogram	Significant narrowing: spinal cord canal or intervertebral foramen.	Recommended.

E. Lumbar Sacral Spine—Continued

Confirmatory test	Minimum result	Requirements
Mechanical complication of internal orthopedic device:		
Medical record review	Documentation of failure of implant following surgical procedure.	Highly recommended.
Osteomalacia:		
X-ray-lumbar sacral spine	Evidence of significant osteomalacia	Recommended.
Magnetic resonance imaging	Evidence of significant osteomalacia	Recommended.
Computerized tomography	Evidence of significant osteomalacia	Recommended.
Osteomyelitis, chronic-lumbar:		
X-ray-lumbar sacral spine	Evidence of chronic infection	Recommended.
Magnetic resonance imaging	Evidence of chronic infection	Recommended.
Computerized tomography	Evidence of chronic infection	Recommended.
Osteoporosis:		
Computerized tomography	Significant bone density loss	Recommended.
Dual photon absorptiometry	Significant bone density loss	Recommended.
X-ray-lumbar sacral spine	Significant bone density loss	Recommended.
Post laminectomy syndrome with radiculopathy:		
Medical record review: lumbar	Documented surgical history of laminectomy.	Highly recommended.
Magnetic resonance imaging	Evidence of laminectomy	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical record review: lumbar	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of laminectomy	Recommended.
Myelogram	Evidence of laminectomy	Recommended.
Radiculopathy:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical record review: lumbar	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Myelogram	Evidence of neural compression	Recommended.
Sciatica:		
Magnetic resonance imaging	Evidence of neural compression	Recommended.
Electromyography	Definite denervation	Recommended.
Nerve conduction velocity	Definite slowing	Recommended.
Physical examination—atrophy	Atrophy in affected limb with 2 cm difference between limbs.	Recommended.
Physical examination: straight leg raise	Positive straight leg raise	Recommended.
Sensory examination	Loss of sensation in affected dermatomes	Recommended.
Medical history	History of radicular pain	Highly recommended.
Computerized tomography	Evidence of neural compression	Recommended.
Myelogram	Evidence of neural compression	Recommended.
Strains and sprains, unspecified:		
Medical record review	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Medical record review	Documented history of strain and/or sprain	Highly recommended.
Spondylolisthesis grade 1:		
X-ray-lumbar sacral spine	1–25% slippage	Recommended.
Computerized tomography	1–25% slippage	Recommended.
Magnetic resonance imaging	1–25% slippage	Recommended.
Spondylolisthesis grade 2:		
X-ray-lumbar sacral spine	26–50% slippage	Recommended.
Computerized tomography	26–50% slippage	Recommended.
Magnetic resonance imaging	26–50% slippage	Recommended.
Spondylolisthesis grade 3:		
X-ray-lumbar sacral spine	51–75% slippage	Recommended.
Computerized tomography	51–75% slippage	Recommended.
Magnetic resonance imaging	51–75% slippage	Recommended.

E. Lumbar Sacral Spine—Continued

Confirmatory test	Minimum result	Requirements
Spondylolisthesis grade 4:		
X-ray-lumbar sacral spine	Complete slippage	Recommended.
Computerized tomography	Complete slippage	Recommended.
Magnetic resonance imaging	Complete slippage	Recommended.
Spondylolisthesis-acquired:		
X-ray-lumbar sacral spine	Slippage	Recommended.
Computerized tomography	Slippage	Recommended.
Magnetic resonance imaging	Slippage	Recommended.
Spondylolsis:		
X-ray-lumbar sacral spine	Defect—pars interarticularis	Recommended.
Computerized tomography	Defect—pars interarticularis	Recommended.
Magnetic resonance imaging	Defect—pars interarticularis	Recommended.
Sprains and strains, sacral:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back with functional limitations for at least 1 year.	Highly recommended.
Medical record review: lumbar	Documented history of strain and/or sprain	Highly recommended.
Sprains and strains, sacroiliac:		
Medical record review: lumbar	History of back pain under medical treatment for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain unresponsive to therapy for at least 1 year.	Highly recommended.
Medical record review: lumbar	History of back pain with functional limitations for at least 1 year.	Highly recommended.
Medical record review: lumbar	Documented history of strain and/or sprain	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: LS SPINE JOB TITLE: TRAINMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves < L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves < L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis—acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D

Disability test	Test result	Disability classification
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: ENGINEER		
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
BODY PART: LS SPINE JOB TITLE: CARMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myeolgram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminshed by 50%	D
BODY PART: LS SPINE JOB TITLE: SIGNALMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifing capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: TRACKMAN		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifing capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physcial examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vetebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	
BODY PART: LS SPINE JOB TITLE: MACHINIST		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade I:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
BODY PART: LS SPINE JOB TITLE: SHOP LABORER		
Ankylosing spondylitis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Backache, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Chronic back pain, not otherwise specified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

Disability test	Test result	Disability classification
Cauda equina syndrome with bowel or bladder dysfunction:		
Computerized tomography	Disc extrusion with neural impingement, nerves <L1.	D
Magnetic resonance imaging	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination	Lower extremity weakness	D
Cystometrogram	Impaired bladder function	D
Myelogram	Disc extrusion with neural impingement, nerves <L1.	D
Physical examination: rectal	Impairment of sphincter tone	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Degeneration of lumbar disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Displacement of lumber disc:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: vertebral body:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: posterior spinal element with no displacement:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture: spinous process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Fracture transverse process:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Intervertebral disc disorder:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Lumbago:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Lumbosacral neuritis:		
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Muscle strength assessment	Lifting capacity diminished by 50%	D
Physical examination	Lower extremity weakness	D
Lumbar spinal stenosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Significant narrowing of the spinal canal	D
Magnetic resonance imaging	Significant narrowing of the spinal canal	D
Myelogram	Significant narrowing of the spinal canal	D
Physical examination	Significant lower extremity weakness	D
Mechanical complication of internal orthopedic device:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Osteomalacia:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Osteomyelitis, chronic-lumbar:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Medical record review	Frequent flare-ups with objective findings	D
Osteoporosis:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Post laminectomy syndrome with radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Post laminectomy syndrome:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D

Disability test	Test result	Disability classification
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
X-ray flexion/extension	Segmental instability	D
Radiculopathy:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Sciatica:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Computerized tomography	Disc extrusion with neural impingement	D
Magnetic resonance imaging	Disc extrusion with neural impingement	D
Myelogram	Disc extrusion with neural impingement	D
Physical examination	Significant lower extremity weakness	D
Strains and sprains, unspecified:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 1:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis grade 2:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 3:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Spondylolisthesis grade 4:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
X-ray flexion/extension	Segmental instability	D
Spondylolisthesis-acquired:		
X-ray flexion/extension	Segmental instability	D
Spondylolysis:		
X-ray flexion/extension	Segmental instability	D
Sprains and strains, sacral:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Sprains and strains, sacroiliac:		
Muscle strength assessment	Lifting capacity diminished by 50%	D
Vertebral body compression fracture:		
Muscle strength assessment	Lifting capacity diminished by 50%	D

F. Cervical Spine

Confirmatory test	Minimum result	Requirements
BODY PART: CE SPINE CONFIRMATORY TESTS		
Cervical disc disease with myelopathy:		
Physical examination: cervical	Evidence of myelopathy	Highly recommended.
Myelogram	Evidence of neurogenic compression	Recommended.
Computerized axial tomography	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Evidence of neurogenic compression	Recommended.
Chronic herniated disc:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Myelogram	Evidence of significant disc degeneration	Recommended.
Computerized axial tomography	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Cervical spondylolysis:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Computerized axial tomography	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Cervical intervertebral disc degeneration:		
X-ray: cervical spine	Evidence of significant disc degeneration	Recommended.
Myelogram	Evidence of significant disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of significant disc degeneration	Recommended.
Fracture: posterior element with spinal canal displacement:		
X-ray: cervical spine	Fractured posterior element with canal displacement.	Recommended.
Computerized axial tomography	Fractured posterior element with canal displacement.	Recommended.
Magnetic resonance imaging	Fractured posterior element with canal displacement.	Recommended.

F. Cervical Spine—Continued

Confirmatory test	Minimum result	Requirements
Fracture: transverse, spinous or posterior process:		
X-ray: cervical spine	Fracture of relevant part	Recommended.
Computerized axial tomography	Fracture of relevant part	Recommended.
Magnetic resonance imaging	Fracture of relevant part	Recommended.
Osteoarthritis, cervical:		
X-ray: cervical spine	Evidence of extensive disc degeneration	Recommended.
Computerized axial tomography	Evidence of extensive disc degeneration	Recommended.
Magnetic resonance imaging	Evidence of extensive disc degeneration	Recommended.
Post laminectomy syndrome:		
Medical records: cervical	Confirmed surgical history	Highly recommended.
Medical records: cervical	Continued pain post-surgery	Highly recommended.
Radiculopathy:		
Medical records: cervical	History of radicular pain	Highly recommended.
Physical examination: arm	Loss of reflexes in affected dermatomes	Recommended.
Physical examination: arm	Evidence of atrophy ≤2 cm	Recommended.
Electromyography	Definite denervation in muscle of affected nerve root.	Recommended.
Myelogram	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Compression of spinal nerves	Recommended.
Computerized axial tomography	Compression of spinal nerves	Recommended.
Rheumatoid arthritis, cervical:		
Rheumatoid factor (blood test)	Titer of rheumatoid factor	Recommended.
X-ray: cervical spine	Rheumatoid changes of spine	Highly recommended.
Medical records review: cervical	Confirmation by rheumatologist or internist	Highly recommended.
Spondylogenic compression of spinal cord:		
Physical examination: cervical	Evidence of myelopathy	Highly recommended.
Computerized axial tomography	Evidence of neurogenic compression	Recommended.
Magnetic resonance imaging	Evidence of neurogenic compression	Recommended.
Myelogram	Evidence of neurogenic compression	Recommended.

Disability test	Test result	Disability classification
BODY PART: CE SPINE JOB TITLE: TRAINMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D

Disability test	Test result	Disability classification
BODY PART: CE SPINE JOB TITLE: ENGINEER		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination:	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: DISPATCHER		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
BODY PART: CE SPINE JOB TITLE: CARMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D

Disability test	Test result	Disability classification
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART; CE SPINE JOB TITLE: SIGNALMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: TRACKMAN		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondyloysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D

Disability test	Test result	Disability classification
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: MACHINIST		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
BODY PART: CE SPINE JOB TITLE: SHOP LABORER		
Cervical disc disease with myelopathy:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Myelogram	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D
Physical examination	Multi-level neurologic compromise	D
Chronic herniated disc:		
Physical examination	Multi-level neurologic compromise	D
Cervical spondylolysis:		
Physical examination	Multi-level neurologic compromise	D
Cervical intervertebral disc degeneration:		
Physical examination	Multi-level neurologic compromise	D
Fracture: posterior element with spinal canal displacement:		
Physical examination	Multi-level neurologic compromise	D
Post laminectomy syndrome:		
Physical examination	Multi-level neurologic compromise	D
Cervical radiculopathy:		
Physical examination	Multi-level neurologic compromise	D
Spondylogenic compression of spinal cord:		
Computerized axial tomography	Significant spinal cord pressure	D
Magnetic resonance imaging	Significant spinal cord pressure	D
Cystometrogram	Impaired bladder function	D
Myelogram	Significant spinal cord pressure	D
Physical examination: rectal	Impairment of sphincter tone	D
Physical examination	Multi-level neurologic compromise	D
Physical examination: lower limb	Lower extremity weakness or significant spasticity.	D

Disability test	Test result	Disability classification
BODY PART: CE SPINE JOB TITLE: SALES REPRESENTATIVE		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
BODY PART: CE SPINE JOB TITLE: GENERAL OFFICE CLERK		
Cervical disc disease with myelopathy:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D
Spondylogenic compression of spinal cord:		
Cystometrogram	Impaired bladder function	D
Physical examination: rectal	Impairment of sphincter tone	D

G. Shoulder and Elbow

Confirmatory test	Minimum result	Requirements.
BODY PART: SHOULDER AND ELBOW CONFIRMATORY TESTS		
Arthritis, acromioclavicular:		
X-ray: shoulder	Significant degenerative changes of joint	Recommended.
Computerized tomography	Significant degenerative changes of joint	Recommended.
Magnetic resonance imaging	Significant degenerative changes of joint	Recommended.
Arthritis, glenohumeral:		
X-ray: shoulder	Significant degenerative changes of joint	Recommended.
Computerized tomography	Significant degenerative changes of joint	Recommended.
Magnetic resonance imaging	Significant degenerative changes of joint	Recommended.
Rotator cuff tear:		
Computerized tomography	Tear of rotator cuff	Recommended.
Magnetic resonance imaging	Tear of rotator cuff	Recommended.
Medical diagnosis leading to a permanent functional limitation of the elbow:		
Medical record review	Condition with permanent functional limitation.	Highly recommended.
X-ray: elbow	Imaging confirmation of functional diagnosis.	Recommended.
Magnetic resonance imaging	Imaging confirmation of functional diagnosis.	Recommended.

Disability test	Test result	Disability classification
BODY PART: SHOULDER AND ELBOW JOB TITLE: TRAINMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: ENGINEER		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D

Disability test	Test result	Disability classification
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of moiton	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: CARMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: SIGNALMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: TRACKMAN		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D
BODY PART: SHOULDER AND ELBOW JOB TITLE: MACHINIST		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D

Disability test	Test result	Disability classification
BODY PART: SHOULDER AND ELBOW JOB TITLE: SHOP LABORER		
Arthritis, acromioclavicular:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Arthritis, glenohumeral:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Rotator cuff tear:		
Physical examination—range of motion	<40 degrees flexion	D
Physical examination—range of motion	<40 degrees abduction	D
Permanent functional limitation, elbow:		
Physical examination	≤40 degrees deviation	D
Physical examination—range of motion	Flexion limit to 60 degrees	D

H. Hand and Arm

Confirmatory test	Minimum result	Requirements
BODY PART: HAND AND ARM CONFIRMATORY TESTS		
Carpal tunnel syndrome:		
Medical record review	Pain, paresthesia and weakness in distribution median nerve.	Highly recommended.
Nerve conduction testing	Definite median nerve conduction slowing at wrist.	Highly recommended.
Electromyography	Denervation in severe cases	Recommended.
Fracture: wrist:		
X-ray: wrist	Evidence of fracture	Highly recommended.
Hand: permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (e.g. X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.
Rheumatoid arthritis: hand:		
Rheumatoid factor	Titer of rheumatoid factor	Recommended.
Medical record review	History of objective findings including serological studies.	Highly recommended.
X-ray: hand	Characteristic rheumatoid changes	Highly recommended.
Tenosynovitis:		
Medical record review	History of chronic tenosynovitis and objective findings.	Highly recommended.
Physical examination	Definite evidence of tenosynovitis	Highly recommended.
Thumb: Permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.
Wrist: Permanent functional limitation:		
Medical record review	Documentation of medical condition for permanent limitation.	Highly recommended.
Physical examination	Definite reproducible evidence of limitation	Highly recommended.
Imaging study (e.g. X-ray, CAT, MRI)	Positive confirmation of underlying condition.	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: HAND AND ARM JOB TITLE: TRAINMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:.		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE ENGINEER		
Fracture, wrist:		
Physical examination—range of motion	Extension-limit to 30 degrees	D
Physical examination—range of motion	Flexion-limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: DISPATCHER		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: CARMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb:	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP of PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SIGNALMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: TRACKMAN		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: MACHINIST		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SHOP LABORER		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: SALES REPRESENTATIVE		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degrees extension	D
Ankylosis: degree from neutral	<40 degrees flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
BODY PART: HAND AND ARM JOB TITLE: GENERAL OFFICE CLERK		
Fracture, wrist:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D
Rheumatoid arthritis hand:		
Physical examination	Significant deformity	D
Medical record review	Significant flare-ups, under treatment with rheumatologist.	D

Disability test	Test result	Disability classification
Medical record review	Extensive medication use, under treatment with rheumatologist.	D
Thumb: permanent functional limitation:		
Adduction of thumb	Loss ≤4 cm	D
Ankylosis: degree from neutral	<20 degree extension	D
Ankylosis: degree from neutral	<40 degree flexion	D
Loss of extension or flexion	MCP or PIP: maximum flexion <40 degrees.	D
Opposition	Loss ≤4 cm	D
Wrist: permanent functional limitation:		
Physical examination—range of motion	Extension—limit to 30 degrees	D
Physical examination—range of motion	Flexion—limit to 30 degrees	D
Physical examination—range of motion	Ankylosis: ≤20 degrees from neutral	D

I. Hip

Confirmatory test	Minimum result	Requirements
BODY PART: HIP CONFIRMATORY TESTS		
Ankylosis, hip:		
X-ray: hip	Extreme joint destruction	Highly Recommended.
Physical examination—range of motion	No mobility	Highly Recommended.
Osteoarthritis, hip:		
X-ray: hip	<4 mm joint space, or other positive evidence.	Recommended.
Magnetic resonance imaging	<4 mm joint space, or other positive evidence.	Recommended.
Computerized axial tomography	<4 mm joint space, or other positive evidence.	Recommended.
Osteomyelitis, hip:		
X-ray: hip	Evidence of chronic infection	Recommended.
Computerized axial tomography	Evidence of chronic infection	Recommended.
Paget's disease:		
X-ray: hip	Osteolytic or blastic lesions	Highly Recommended.
Alkaline phosphatase	Increased up to 50 times	Highly Recommended.
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip	Recommended.
Medical record review	Documentation of prior hip replacement	Recommended.

Disability test	Test result	Disability classification
BODY PART: HIP JOB TITLE: TRAINMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D

Disability test	Test result	Disability classification
BODY PART: HIP JOB TITLE: ENGINEER		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Signficant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: CARMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: SIGNALMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D

Disability test	Test result	Disability classification
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: TRACKMAN		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: MACHINIST		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees or ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abudction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D

Disability test	Test result	Disability classification
Medical record review	Documentation of prior hip replacement	D
BODY PART: HIP JOB TITLE: SHOP LABORER		
Ankylosis, hip:		
Physical examination—range of motion	Ankylosis 5 degrees of ≤flexion	D
Physical examination—range of motion	Ankylosis internal rotation ≤5 degrees	D
Physical examination—range of motion	Ankylosis external rotation ≤10 degrees	D
Physical examination—range of motion	Ankylosis in abduction ≤5 degrees	D
Physical examination—range of motion	Ankylosis in adduction ≤5 degrees	D
Osteoarthritis, hip:		
X-ray: hip	0 mm cartilage interval	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Osteomyelitis, chronic hip:		
X-ray: hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Medical record review	Documented occurrence of recurring infections with treatment.	D
Paget's disease:		
X-ray; hip	Significant joint destruction	D
Physical examination—range of motion	30 degrees flexion contracture	D
Physical examination—range of motion	<50 degrees flexion	D
Physical examination—range of motion	<5 degrees abduction	D
Hip replacement surgery:		
X-ray: hip	Evidence of artificial hip joint	D
Medical record review	Documentation of prior hip replacement	D

J. Knee

Confirmatory test	Minimum result	Requirements
BODY PART: KNEE CONFIRMATORY TESTS		
Arthritis: knee:		
X-ray: knee	Evidence of significant degenerative changes.	Recommended.
Collateral ligament tear with laxity:		
Physical examination: knee	Evidence of ligamentous laxity	Highly Recommended.
Magnetic resonance imaging	Evidence of ligamentous tear	Recommended.
Cruciate and collateral ligament tear with laxity:		
Magnetic resonance imaging	Tear of both ligaments	Recommended.
Physical examination	Evidence of ligamentous laxity	Highly Recommended.
Medical record review	Documentation of tear by arthroscopy	Recommended.
Cruciate ligament tear with laxity:		
Physical examination: knee	Evidence of ligamentous laxity	Highly Recommended.
Magnetic resonance imaging	Evidence of cruciate tear	Recommended.
Medical record review	Documentation of tear by arthroscopy	Recommended.
Intercondylar fracture:		
X-ray: knee	Evidence of fracture	Highly Recommended.
Osteomyelitis: knee:		
Medical record review	Documented history of osteomyelitis requiring treatment.	Highly Recommended.
X-ray: knee	Evidence of chronic infection	Recommended.
Computerized tomography	Evidence of chronic infection	Recommended.
Magnetic resonance imaging	Evidence of chronic infection	Recommended.
Osteonecrosis:		
X-ray: knee	Necrosis of femoral condyle or tibial plateau.	Recommended.
Computerized tomography	Necrosis of femoral condyle or tibial plateau.	Recommended.
Magnetic resonance imaging	Necrosis of femoral condyle or tibial plateau.	Recommended.
Patellofemoral arthritis:		
X-ray: knee	Evidence of arthritis	Recommended.
Magnetic resonance imaging	Evidence of arthritis	Recommended.
Physical examination	Crepitation with movement	Highly Recommended.

J. Knee—Continued

Confirmatory test	Minimum result	Requirements
Patellar fracture nonunion with displacement:		
X-ray: knee	Nonunion and displacement	Recommended.
Magnetic resonance imaging	Nonunion and displacement	Recommended.
Computerized tomography	Nonunion and displacement	Recommended.
Plateau fracture:		
X-ray: knee	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Meniscectomy—medial or lateral:		
Medical record review	History of surgery	Highly Recommended.
Patellectomy:		
Physical examination: knee	Absent patella	Highly Recommended.
Patellar—subluxation—recurrent:		
Medical record review	History of recurrent subluxation	Highly Recommended.
Supracondylar fracture:		
X-ray: knee	Evidence of fracture	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.
Total knee replacement:		
X-ray: knee	Presence of replacement knee	Recommended.
Medical record review	Documented surgical history	Recommended.
Tibial shaft fracture:		
X-ray: leg	Fracture of shaft	Recommended.
Magnetic resonance imaging	Evidence of fracture	Recommended.
Computerized tomography	Evidence of fracture	Recommended.

Disability test	Test result	Disability classification
BODY PART: KNEE JOB TITLE: TRAINMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D

Disability test	Test result	Disability classification
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: ENGINEER		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: CARMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:.		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D

Disability test	Test result	Disability classification
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: SIGNALMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D

Disability test	Test result	Disability classification
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: TRACKMAN		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degree angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D

Disability test	Test result	Disability classification
X-ray knee: patello femoral joint	0 mm cartilage interval with degenerative change.	D
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: MACHINIST		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0 mm cartilage interval with degenerative change.	D

Disability test	Test result	Disability classification
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D
BODY PART: KNEE JOB TITLE: SHOP LABORER		
Arthritis knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Meniscectomy, medial or lateral:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Collateral ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate and collateral ligament tear:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Cruciate ligament tear with laxity:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Intercondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Osteomyelitis, chronic knee:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
Medical record review	Frequent episodes of infection requiring treatment.	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Osteonecrosis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee	0–1 mm cartilage interval with degenerative change.	D
Patellofemoral arthritis:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Physical examination	Valgus deformity, 16–20 degrees	D
Physical examination	Varus deformity, 8–12 degrees	D
X-ray knee: patellofemoral joint	0 mm cartilage interval with degenerative change.	D

Disability test	Test result	Disability classification
Patellar fracture nonunion with displacement:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
X-ray knee	Nonunion and ≤3 mm displacement	D
Plateau fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellectomy:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Patellar, subluxation, recurrent:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Supracondylar fracture:		
Post fracture angulation	≤20 degrees angulation	D
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Tibial shaft fracture:		
Physical examination—range of motion	Range of motion: flexion <60 degrees	D
Physical examination—range of motion	Flexion contracture (20 or ≤ degrees)	D
Post fracture angulation	≤20 degrees malalignment	D

K. Ankle and Foot

Confirmatory test	Minimum result	Requirements
BODY PART: ANKLE AND FOOT CONFIRMATORY TESTS		
Ankle fracture:		
Medical record review	Documented history of ankle fracture	Recommended.
X-ray: ankle	Ankle fracture	Highly recommended.
Ankylosis, ankle:		
X-ray: ankle	Extensive joint destruction	Highly recommended.
Physical examination	No mobility	Highly recommended.
Arthritis, subtalar joint:		
X-ray: ankle	Evidence of significant arthritis: subtalar joint.	Highly recommended.
Arthritis, talonavicular joint:		
X-ray: ankle	Significant arthritis: talonavicular joint	Highly recommended.
Achilles tendon rupture:		
Medical record review	Documentation of achilles tendon rupture	Highly recommended.
Physical examination	Rupture of achilles tendon	Highly recommended.
Arthritis, ankle:		
X-ray: ankle	Significant arthritis	Highly recommended.
Hindfoot fracture:		
X-ray: foot and ankle	Documentation of fracture	Highly recommended.
Rheumatoid arthritis, foot:		
Medical History	Documented history of condition	Highly recommended.
X-ray: foot	Significant arthritis	Highly recommended.

Disability test	Test result	Disability classification
BODY PART: ANKLE AND FOOT JOB TITLE: TRAINMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability, <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture, 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability, <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture, 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: ENGINEER		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: DISPATCHER		
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: CARMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorisiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylois in int or ext malrotation ≤15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	0
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare—up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: SIGNALMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees.	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot) ...	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot) ..	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: TRACKMAN		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination—range of motion	Varus deformity ≤15 degrees	D
Physical examinaton—range of motion	Plantar flexion capability ≤5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: angle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot) ...	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot) ..	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D

Disability test	Test result	Disability classification
BODY PART: ANKLE AND FOOT JOB TITLE: MACHINIST		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D
BODY PART: ANKLE AND FOOT JOB TITLE: SHOP LABORER		
Ankle fracture:		
X-ray: ankle	Displaced intra-articular fracture	D
Physical examination	Varus deformity ≤15 degrees	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Ankylosis, ankle:		
Physical examination—range of motion	Ankylosis in 20 degree or ≤ dorsiflexion	D
Physical examination—range of motion	Ankylosis in 20 degree plantar flexion	D
Physical examination—range of motion	Ankylosis in int or ext malrotation ≤15 degrees.	D
Physical examination—range of motion	Ankylosis in varus 10 or more degrees	D
Physical examination—range of motion	Ankylosis in valgus 10 or more degrees	D
Arthritis, subtalar joint (hindfoot):		
X-ray: ankle—subtalar joint	Subtalar joint space 0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Arthritis, talonavicular joint (hindfoot):		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
X-ray: ankle—talonavicular joint	Talonavicular joint space 0 mm	D
Physical examination	Varus deformity ≤15 degrees	D
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D

Disability test	Test result	Disability classification
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D

Disability test	Test result	Disability classification
BODY PART: ANKLE AND FOOT JOB TITLE: SALES REPRESENTATIVES		
Achilles tendon rupture:		
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Arthritis, ankle:		
X-ray: ankle	0 mm	D
Physical examination—range of motion	Plantar flexion capability <5 degrees	D
Physical examination—range of motion	Plantar flexion contracture 20 degrees	D
Physical examination	Varus deformity ≤15 degrees	D
Hindfoot fracture:		
X-ray: foot	Calcaneal fracture with Boehler angle <95 degrees.	D
X-ray: foot	Subtalar fracture with Boehler angle <95 degrees.	D
Physical examination	Varus angulation ≤20 degrees (hindfoot)	D
Physical examination	Valgus angulation ≤20 degrees (hindfoot)	D
Rheumatoid arthritis, foot:		
X-ray: foot	Significant degeneration	D
Medical record review	Chronic flare-up with treatment	D

JOB INFORMATION FORMS

Form Approved
OMB No. 3220-0193

JOB INFORMATION FORM

RRB Claim Number
Employee's Name
Date Released
Regular Railroad Occupation*
Location
Date Last Worked

* The regular railroad occupation is: 1) the occupation in which the employee has been engaged for more calendar months than any other occupation during the last preceding 5 calendar years, whether consecutive or not; or 2) the occupation which the employee has been in service for not less than one-half of all months in which the employee has been engaged in service during the last 15 consecutive calendar years; or 3) if an employee last worked as an officer or employee of a railway labor organization and if that employment is no longer available, the regular occupation shall be the position to which the employee holds seniority rights or the position left to work for the railway labor organization.

The above-named railroad employee has applied for an occupational disability benefit under section 2(a)(iv) of the Railroad Retirement Act. Railroad Retirement Board (RRB) regulation 20 CFR 220.13 (b)(2) provides that railroad employers may furnish pertinent information concerning the job duties the employee is required to perform. If you wish to provide job duty information on the above-named employee, it must be received by the RRB no later than _____.

EMPLOYER INFORMATION

The attached list of job duties indicate those duties generally performed by the employee.

Please provide any additional information on the duties the employee performed over the last 5 years, or 15 years if appropriate.

This information can be entered in the Remarks section or attached to this form.

G-251a(12-97)

Job information should be sent to:

U.S. RAILROAD RETIREMENT BOARD
844 NORTH RUSH STREET
CHICAGO, ILLINOIS 60611-2092
ATTENTION: DISABILITY PROGRAMS SECTION

or a facsimile may be sent to (312)751-7167.

Employer Certification - The information contained in this report is correct to the best of my knowledge and belief.

NAME _____ SIGNATURE _____
(Please Print)
TITLE _____ DATE ____/____/____
(Please Print)
TELEPHONE NO (____) _____

Remarks:

Paperwork Reduction Act Notice

Section 7 (b)(6) of the Railroad Retirement Act (RRA) allows the Railroad Retirement Board (RRB) to collect this information. While you are not required to respond, the information you provide will be used by the RRB in determining an applicant's eligibility for an occupational disability under the RRA.

We estimate that this form takes an average of 20 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. *Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number.* If you wish, send comments regarding the accuracy of our estimate or any other aspects of this form, including suggestions for reducing the completion time to: Chief of Information Management, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 60611-2092 and to the Office of Management and Budget, Paperwork Reduction Project (3220-0193), Washington DC 20503. Please do **not** return this form to either of these addresses.

G-251a (12-97)

Form Approved
OMB No. 3220-0193

JOB INFORMATION FORM

RRB Claim Number
Employee's Name
Date Released
Regular Railroad Occupation*
Location
Date Last Worked

* The regular railroad occupation is: 1) the occupation in which the employee has been engaged for more calendar months than any other occupation during the last preceding five calendar years, whether consecutive or not; or 2) the occupation which the employee has been in service for not less than one-half of all months in which the employee has been engaged in service during the last 15 consecutive calendar years; or 3) if an employee last worked as an officer or employee of a railway labor organization and if that employment is no longer available, the regular occupation shall be the position to which the employee holds seniority rights or the position left to work for the railway labor organization.

The above-named railroad employee has applied for an occupational disability benefit under section 2(a)(iv) of the Railroad Retirement Act. Railroad Retirement Board (RRB) regulation 20 CFR 220.13 (b)(2) provides that railroad employers may furnish pertinent information concerning the job duties the employee is required to perform. If you wish to provide job duty information on the above-named employee, it must be received by the RRB no later than _____.

EMPLOYER INFORMATION

You may wish to provide the RRB with job duty information. If so, the job information that is needed for a disability decision should include a full description of the basic duties to perform the occupation listed. For example, list the types of machinery, tools and/or equipment used, technical knowledge or skills involved, and number of people supervised. Also include the types of physical activities involved in a typical 8 hour work day, such as how many hours of walking, standing or sitting, what items are lifted and carried and how much these items weigh, and how often bending, crouching, kneeling, reaching and climbing are performed. If exposure to environmental hazards, such as working at heights or around dangerous machinery, in extreme temperatures or excessive noise are present, also list these.

G-251b(12-97)

This information can be entered in the Remarks section or attached to this form.

Job information should be sent to:

U.S. RAILROAD RETIREMENT BOARD
844 NORTH RUSH STREET
CHICAGO, ILLINOIS 60611-2092
ATTENTION: DISABILITY PROGRAMS SECTION

or a facsimile may be sent to (312)751-7167.

Employer Certification - The information contained in this report is correct to the best of my knowledge and belief.

NAME _____ SIGNATURE _____
(Please Print)

TITLE _____ DATE ____/____/____
(Please Print)

TELEPHONE NO (____)_____

Remarks:

Paperwork Reduction Act Notice

Section 7 (b)(6) of the Railroad Retirement Act (RRA) allows the Railroad Retirement Board (RRB) to collect this information. While you are not required to respond, the information you provide will be used by the RRB in determining an applicant's eligibility for an occupational disability under the RRA.

We estimate that this form takes an average of 20 minutes per response to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. *Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number.* If you wish, send comments regarding the accuracy of our estimate or any other aspects of this form, including suggestions for reducing the completion time to: Chief of Information Management, Railroad Retirement Board, 844 North Rush Street, Chicago, IL 60611-2092 and to the Office of Management and Budget, Paperwork Reduction Project (3220-0193), Washington DC 20503. Please do **not** return this form to either of these addresses.

G-251b (12-97)

[63 FR 7543, Feb. 13, 1998]

PART 221—JURISDICTION DETERMINATIONS

Sec.
221.1 Introduction.
221.2 Railroad Retirement Board jurisdiction.
221.3 Social Security Administration jurisdiction.
221.4 When a jurisdiction decision may be reversed.

AUTHORITY: Sec. 7(b)(1), Pub. L. 94–547 (45 U.S.C. 231f(b)(1)).

SOURCE: 47 FR 7656, Feb. 22, 1982, unless otherwise noted.

§ 221.1 Introduction.

This part explains the factors involved in deciding whether the Social

Security Administration or the Railroad Retirement Board will pay benefits to a railroad employee, and his or her eligible family members, both before and after the employee's death. The agency that has jurisdiction over the payment of benefits also has jurisdiction of the applicant's medicare coverage (see part 270 of this chapter). The Board is responsible for making this decision.

§ 221.2 Railroad Retirement Board jurisdiction.

(a) *Life cases.* The Board has jurisdiction to pay monthly benefits to each living employee who has completed at least ten years (120 months) of creditable service under the Railroad Retirement Act, and to his or her eligible spouse. Creditable service is described in part 220 of this chapter.

(b) *Death cases.* The Board has jurisdiction to pay monthly benefits or lump-sum death benefits to eligible survivors of a deceased employee, when the deceased employee has at least ten years (120 months) of service that is creditable under the Railroad Retirement Act and a current connection as described in part 216 of this chapter. Lump-sum death benefits are described in part 234 of this chapter. The Board also has jurisdiction to pay any residual benefits that may become payable at the death of an employee. Residual benefits are described in part 234 of this chapter. The Board retains jurisdiction to pay any residual that may be payable even after jurisdiction has been transferred to the Social Security Administration as described in § 221.3.

§ 221.3 Social Security Administration jurisdiction.

The Board transfers jurisdiction (railroad service and compensation credits earned by the employee which the Social Security Administration considers in determining benefits payable) to the Social Security Administration when—

(a) *Life and death cases.* A living or deceased employee has less than 120 months of service that is creditable under the Railroad Retirement Act; or

(b) *Death cases.* A deceased employee has at least 120 months of service that is creditable under the Railroad Retirement Act (see part 220 of this chapter) but does not have a current connection with the railroad industry as described in part 216 of this chapter.

§ 221.4 When a jurisdiction decision may be reversed.

The Board may reverse a jurisdiction decision whenever evidence is received by the Board indicating that the original decision was incorrect.

PART 222—FAMILY RELATIONSHIPS

Subpart A—General

Sec.

222.1 Introduction.
222.2 Definitions.
222.3 Other regulations related to this part.
222.4 Homicide of employee.

Subpart B—Relationship as Wife, Husband, or Widow(er)

222.10 When determinations of relationship as wife, husband, widow or widower of employee are made.
222.11 Determination of marriage relationship.
222.12 Ceremonial marriage relationship.
222.13 Common-law marriage relationship.
222.14 Deemed marriage relationship.
222.15 When spouse is living with employee.
222.16 When spouse is living in the same household with employee.
222.17 ''Child in care'' when child of the employee is living with the claimant.
222.18 ''Child in care'' when child of the employee is not living with the claimant.

Subpart C—Relationship as Divorced Spouse, Surviving Divorced Spouse, or Remarried Widow(er)

222.20 When determination of relationship as divorced spouse, surviving divorced spouse, or remarried widow(er) is made.
222.21 When marriage is terminated by final divorce.
222.22 Relationship as divorced spouse.
222.23 Relationship as surviving divorced spouse.
222.24 Relationship as remarried widow(er).

Subpart D—Relationship as Child

222.30 When determinations of relationship as child are made.
222.31 Relationship as child for annuity and lump-sum payment purposes.
222.32 Relationship as a natural child.
222.33 Relationship resulting from legal adoption.

222.34 Relationship resulting from equitable adoption.
222.35 Relationship as stepchild.
222.36 Relationship as grandchild or stepgrandchild.

Subpart E—Relationship as Parent, Grandchild, Brother or Sister

222.40 When determinations of relationship are made for parent, grandchild, brother or sister.
222.41 Determination of relationship and support for parent.
222.42 When employee is contributing to support.
222.43 How the one-half support determination is made.
222.44 Other relationship determinations for lump-sum payments.

Subpart F—Child Support and Dependency

222.50 When child dependency determinations are made.
222.51 When a natural child is dependent.
222.52 When a legally adopted child is dependent—general.
222.53 When a legally adopted child is dependent—child adopted after entitlement.
222.54 When a legally adopted child is dependent—grandchild or stepgrandchild adopted after entitlement.
222.55 When a stepchild is dependent.
222.56 When a grandchild or stepgrandchild is dependent.
222.57 When an equitably adopted child is dependent.
222.58 When a child is living with an employee.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 54 FR 42949, Oct. 19, 1989, unless otherwise noted.

Subpart A—General

§ 222.1 Introduction.

This part sets forth and describes the family relationships that may make a claimant eligible for an annuity or lump-sum payment under the Railroad Retirement Act and furnishes the basic rules for determining when those relationships exist. Such relationships may result from a current or terminated marriage or through birth, death or adoption. Other relevant relationships are having a child in care, dependency or lack of it, contributing to support, living in the same household, and being under court order to contribute to support.

§ 222.2 Definitions.

As used in this part—

Annuity means a payment under the Railroad Retirement Act due to an entitlement claimant for a calendar month and made to him or her on the first day of the following month.

Apply means to sign a form or statement that the Railroad Retirement Board accepts as an application for an annuity or lump-sum payment under the rules set out in part 217 of this chapter.

Child has differing definitions for annuity and lump-sum payment purposes. See § 222.31.

Claimant means a person who files an application for an annuity or lump-sum payment or for whom an application is filed.

Eligible means that a person would meet all the requirements for payment of an annuity or lump-sum payment as of a given date but has not yet applied therefor.

Employee means an employee as defined in part 203 of this chapter.

Final divorce means a divorce that completely dissolves a marriage and restores the parties to the status of single persons; it is also referred to as an absolute divorce.

Finally divorced person means a person whose marriage has been terminated or dissolved by a final divorce.

Legal impediment means that there was a defect in the procedures followed in a marriage ceremony or that a previous marriage of the employee or spouse had not ended at the time of the ceremony.

Lump-sum payment means any of the following payments under the Railroad Retirement Act: lump-sum death payment, residual lump-sum, annuities due but unpaid at death, or lump-sum refund payment (see part 234 of this chapter).

Marriage means the social and legal relationship of husband and wife for family relationship purposes, as well as the act by which the married state is effected.

Permanent home means the employee's true and fixed home (legal domicile); it is the place to which the employee intends to return whenever he or she is absent therefrom.

Relationship means a family connection by blood, marriage, or adoption between the employee and another person who is a claimant.

Spouse means the husband or wife of the employee.

State law means the law of the State in which the employee has his or her permanent home or, in the case of a deceased employee, the law of the State in which the employee had his or her permanent home at the time of his or her death. If the employee's permanent home is not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, the laws of the District of Columbia are applied.

§ 222.3 Other regulations related to this part.

This part is related to a number of other parts of this chapter:

Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

Part 217 describes how to apply for an annuity or for lump-sum payments.

Part 218 sets forth the beginning and ending dates of annuities.

Part 219 sets out what evidence is necessary to prove eligibility and the relationships described in this part.

Part 220 describes when a person is eligible for a disability annuity under the Railroad Retirement Act or a period of disability under the Social Security Act.

Part 225 explains how primary insurance amounts (PIA's) are computed.

Part 226 outlines the computation of employee and spouse annuities.

Part 228 describes how survivor annuities are computed.

Part 229 describes when and how an employee and spouse annuity may be increased under the social security overall minimum provision.

Part 234 describes lump-sum payments under the Railroad Retirement Act.

§ 222.4 Homicide of employee.

No person convicted of the felonious and intentional homicide of an employee can be entitled to an annuity or lump-sum payment based on the employee's earnings record (service and compensation). Further, the convicted person is considered not to exist in deciding the rights of other persons to annuity or lump-sum payments. A minor may be denied a survivor annuity or lump-sum payment on the earnings record of a parent if the minor was convicted of intentionally causing the parent's death by an act which would be considered a felony if committed by an adult.

Subpart B—Relationship as Wife, Husband, or Widow(er)

§ 222.10 When determinations of relationship as wife, husband, widow or widower of employee are made.

(a) The claimant's relationship as the wife or husband of an employee is determined when the claimant applies for an annuity, or when there is a claim which would include a husband or wife in the computation of the social security overall minimum provision, or when a claim is filed for a lump-sum payment. If a deemed marriage (see § 222.14) is to be determined, the husband, wife, or widow(er) must also be found to be or to have been living in the same household as the employee (see § 222.16).

(b) The claimant's relationship as the widow(er) of an employee is determined as of the date on which the employee died. If the claimant applied for a lump-sum payment as the widow(er) of the employee, one of the following determinations is made:

(1) Whether the widow(er) was living in the same household as the employee, as defined in § 222.16 of this part, at the time of the employee's death, if the claimant is applying for the 1974 Act lump-sum death payment.

(2) Whether the widow(er) was living with the employee, as defined in § 222.15 of this part, at the time of the employee's death, if the claimant is applying for the 1937 Act lump-sum death payment, annuities due but unpaid at death, the residual lump-sum payment, or a lump-sum refund payment.

(c) In order for a claimant who has applied for a monthly survivor annuity to establish a deemed marriage, the claimant must have been living in the same household as the employee at the time of the employee's death (see § 222.16).

(d) If the husband, wife, widow(er), remarried widow(er), or surviving divorced spouse of the employee is a claimant for a monthly annuity on a basis other than age or disability, a child-in-care determination is required (see §§ 222.17 and 222.18).

§ 222.11 Determination of marriage relationship.

A claimant will be considered to be the husband, wife, or widow(er) of an employee if the law of the State in which the employee has or had a permanent home would recognize that the claimant and employee were validly married, or if a deemed marriage is established.

(a) Generally, State courts will find that a claimant and employee were validly married if—

(1) The employee and claimant were married in a civil or religious ceremony (see § 222.12) or

(2) The employee and claimant live together in a common-law marriage relationship which is recognized under applicable State law (see § 222.13), and no impediment to the marriage existed at the time it took place.

(b) A deemed marriage relationship may be established as described in § 222.14.

§ 222.12 Ceremonial marriage relationship.

A valid ceremonial marriage is one which would be recognized as valid by the courts of the State in which the marriage ceremony took place. Generally, State law provides various procedures which must be followed, such as designation of who may perform the marriage ceremony, what licenses or witnesses are required, and similar rules. A ceremonial marriage may be a civil or religious ceremony, or a ceremony which follows tribal customs, Chinese customs, or similar traditional procedures.

§ 222.13 Common-law marriage relationship.

Under the laws of some States, a common-law marriage is one which is not solemnized in a formal ceremony, but is generally evidenced by a consummated agreement to marry between two persons legally capable of making a marriage contract, followed by cohabitation. The laws of the various States which recognize common-law marriage delineate specific factors which must be present in order to establish a valid common-law marriage in those States.

§ 222.14 Deemed marriage relationship.

If a ceremonial or common-law marriage relationship cannot be established under State law, a claimant may still be found to have the relationship as spouse of an employee based upon a deemed marriage. A claimant is deemed to be the wife, husband, or widow(er) of the employee if the person's marriage to the employee would have been valid under State law except for a legal impediment, and all of the following requirements are met:

(a) The claimant married the employee in a civil or religious ceremony.

(b) The claimant went through the marriage ceremony in good faith. Good faith means that at the time of the ceremony the claimant did not know that a legal impediment existed, or if the claimant did know, he or she thought that it would not prevent a valid marriage.

(c) The claimant was living in the same household as the employee (see § 222.16) when he or she applied for the spouse annuity or when the employee died.

[54 FR 42949, Oct. 19, 1989, as amended at 65 FR 20726, Apr. 18, 2000]

§ 222.15 When spouse is living with employee.

A spouse, or widow(er) is living with the employee if—

(a) He or she and the employee are living in the same household; or

(b) The employee is contributing to the support of the spouse or widow(er); or

(c) The employee is under court order to contribute to the support of the spouse or widow(er).

§ 222.16 When spouse is living in the same household with employee.

(a) Living in the same household means that the employee and spouse customarily live together as a married couple in the same residence.

(b) The employee and spouse are also considered members of the same household when they live apart but expect to resume or continue living together after a temporary separation.

(c) If the employee and spouse were separated solely for medical reasons, the Board will consider them ''living in the same household'' even if the separation was likely to be permanent.

§ 222.17 "Child in care" when child of the employee is living with the claimant.

''Child in care'' means a child who has been living with the claimant for at least 30 consecutive days unless—

(a) The child is in active military service;

(b) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older and is not disabled;

(c) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older with a mental disability and the claimant does not exercise parental control and responsibility; or

(d) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older with a physical disability, but it is not necessary for the claimant to perform personal services for the child.

(e) Parental control and responsibility for the care and welfare of the child means that the parent supervises the child's activities and makes important decisions about the child's needs either alone or with another person. Personal services are services such as dressing, feeding and managing money which the child cannot do alone because of a disability.

§ 222.18 "Child in care" when child of the employee is not living with the claimant.

(a) *When child is in care.* A child living apart from a claimant is in that claimant's care if—

(1) The child lives apart or is expected to live apart from the claimant for not more than six months; or

(2) The child is under 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities), the claimant supervises the child's activities and makes important decisions about his or her needs, and one of the following circumstances applies:

(i) The child is living apart because of attendance at school but generally spends a vacation of at least 30 consecutive days with the claimant each year, and, if the claimant and the child's other parent are separated, the school must look to the claimant for decisions about the child's welfare.

(ii) The child is living apart because of the claimant's employment but the claimant makes regular and substantial contributions to the child's support. ''Contributing to support'' is defined in § 222.42.

(iii) The child is living apart because of the child's or the claimant's physical disability; or

(3) The child is 18 years old (16 with respect to male spouse, divorced spouse, surviving divorced spouse, or remarried widow(er) annuities) or older and is mentally disabled and the claimant supervises the child's activities, makes important decisions about the child's needs, and helps in the child's upbringing and development.

(b) *When child is not in care.* A child livng apart from a claimant is not in the claimant's care if—

(1) The child is in active military service; or

(2) The child is living with his or her other parent; or

(3) A court order removed the child from the claimant's custody and control; or

(4) The claimant gave the right to custody and control of the child to someone else; or

(5) The claimant is mentally disabled.

Subpart C—Relationship as Divorced Spouse, Surviving Divorced Spouse, or Remarried Widow(er)

§ 222.20 When determination of relationship as divorced spouse, surviving divorced spouse, or remarried widow(er) is made.

(a) *Divorced spouse.* The claimant's relationship as the divorced spouse of an employee is determined when the purported divorced spouse applies for an annuity, or when there is a claim which would include a divorced spouse in the computation of the social security overall minimum provision. Such a determination is also made when a spouse annuitant age 62 or over secures a final divorce from the employee after 10 years of marriage.

(b) *Surviving divorced spouse.* The claimant's relationship as the surviving divorced spouse of an employee is determined when the purported surviving divorced spouse applies for an annuity on the basis of age, disability, or having a child in care. Such a determination is also made when there is a divorced spouse annuitant and the employee dies.

(c) *Remarried widow(er).* The claimant's relationship as a remarried widow(er) of an employee is determined when the purported remarried widow(er) applies for an annuity. Such a determination is also made when a widow(er) who is receiving an annuity remarries after age 60, or when a widow(er) who is receiving a disability annuity remarries after age 50.

§ 222.21 When marriage is terminated by final divorce.

A final divorce, often referred to as an absolute divorce, completely dissolves the marriage relationship and restores the parties to the status of single persons. A legal separation, qualified or preliminary divorce, divorce from bed and board, interlocutory decree of divorce, or similar court order is not considered a final divorce for family relationship and benefit entitlement purposes.

§ 222.22 Relationship as divorced spouse.

A claimant will be considered to be the divorced spouse of an employee if—

(a) His or her marriage to the employee has been terminated by a final divorce; and

(b) He or she is not married (if the claimant remarried after the divorce from the employee, the later marriage has been terminated by death, final divorce, or annulment); and

(c) He or she had been validly married to the employee, as set forth in § 222.11, for a period of 10 years immediately before the date the divorce became final. The claimant meets this requirement even if the claimant and employee were divorced within the ten-year period, provided that the claimant and employee were remarried no later than the calendar year immediately following the year in which the divorce took place.

§ 222.23 Relationship as surviving divorced spouse.

A claimant will be considered to be the surviving divorced spouse of a deceased employee if the conditions in either paragraph (a) or (b) of this section are met:

(a) *Age or disability.* The claimant applied for an annuity on the basis of age or disability, and the conditions set forth in § 222.22 are met.

(b) *Child in care.* The claimant applied for an annuity on the basis of having a child in care, and—

(1) His or her marriage to the employee has been terminated by a final divorce; and

(2) He or she is not married (if the claimant remarried after the divorce from the employee, the later marriage has been terminated by death, final divorce, or annulment); and

(3) He or she either—

(i) Was the natural parent of the employee's child; or

(ii) Had been married to the employee when either the employee or the claimant legally adopted the other's child or when they both legally adopted a child who was then under 18 years of age.

§ 222.24 Relationship as remarried widow(er).

(a) *New eligibility.* A claimant will have the relationship of a remarried widow(er) if he or she is the widow(er), as discussed in § 222.11, of an employee and the claimant—

(1) Remarried after attaining age 60, or remarried after attaining age 50 and after the date on which he or she became disabled; or

(2) Remarried before attaining age 60, but is now unmarried, or remarried before attaining age 50 or before the date on which he or she became disabled, but is now unmarried.

(b) *Reentitlement.* A claimant will have the relationship of a remarried widow(er) if he or she remarries after his or her entitlement to an annuity as a widow(er) has been established, and the claimant—

(1) Remarries after attaining age 60, or remarries after attaining age 50 and after the date on which he or she became disabled; or

(2) Is entitled to an annuity based upon having a child of the employee in care and remarries, but this marriage is to a person who is entitled to a retirement, disability, widow(er)'s, mother's, father's, parent's, or disabled child's benefit under the Railroad Retirement Act or Social Security Act.

Subpart D—Relationship as Child

§ 222.30 When determinations of relationship as child are made.

(a) Determinations will be made regarding a person's relationship as the child of the employee and that person's dependency on the employee (see subpart F of this part) when—

(1) The wife or husband of an employee applies for a spouse's annuity based on having the employee's child in care; or

(2) The employee's annuity can be increased under the social security overall minimum provision based on the child; or

(3) The employee dies and the claimant applies for a child's annuity.

(b) A determination will be made regarding a claimant's relationship as the child of the employee when the claimant applies for a share of a lump-sum payment as a child.

§ 222.31 Relationship as child for annuity and lump-sum payment purposes.

(a) *Annuity claimant.* When there are claimants under paragraph (a)(1), (a)(2), or (a)(3) of § 222.30, a person will be considered the child of the employee when that person is—

(1) The natural or legally adopted child of the employee (see § 222.33); or

(2) The stepchild of the employee; or

(3) The grandchild or step-grandchild of the employee or spouse; or

(4) The equitably adopted child of the employee.

(b) *Lump-sum payment claimant.* A claimant for a lump-sum payment must be one of the following in order to be considered the child of the employee:

(1) The natural child of the employee;

(2) A child legally adopted by the employee (this does not include any child adopted by the employee's widow or widower after the employee's death); or

(3) The equitably adopted child of the employee. For procedures on how a determination of the person's relationship to the employee is made, see §§ 222.32–222.33.

[65 FR 20726, Apr. 18, 2000]

§ 222.32 Relationship as a natural child.

A claimant will be considered the natural child of the employee for both annuity and lump-sum payment purposes if one of the following sets of conditions is met:

(a) *State inheritance law.* Under relevant state inheritance law, the claimant could inherit a share of the employee's personal estate as the employee's natural child if the employee were to die without leaving a will as described in paragraph (e) of this section;

(b) *Natural child.* The claimant is the employee's natural son or daughter, and the employee and the claimant's mother or father went through a marriage ceremony which would have been valid except for a legal impediment;

(c) *By order of law.* The claimant's natural mother or father has not married the employee, but—

(1) The employee has acknowledged in writing that the claimant is his or her son or daughter; or

(2) A court has decreed that the employee is the mother or father of the claimant; or

(3) A court has ordered the employee to contribute to the claimant's support because the claimant is the employee's son or daughter; and,

(4) Such acknowledgment, court decree, or court order was made not less than one year before the employee became entitled to an annuity, or in the case of a disability annuitant prior to his or her most recent period of disability, or in case the employee is deceased, prior to his or her death. The written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(d) Other evidence of relationship. The claimant's natural mother or father has not married the employee, but—

(1) The claimant has submitted evidence acceptable in the judgment of the Board, other than that discussed in paragraph (c) of this section, that the employee is his or her natural mother or father; and

(2) The employee was living with the claimant or contributing to the claimant's support, as discussed in §§ 222.58 and 222.42 of this part, when—

(i) The spouse applied for an annuity based on having the employee's child in care; or

(ii) The employee's annuity could have been increased under the social security overall minimum provision; or

(iii) The employee died, if the claimant is applying for a child's annuity or lump-sum payment.

(e) *Use of state laws*—(1) *General.* To determine whether a claimant is the natural child of the employee, the state inheritance laws regarding whether the claimant could inherit a child's share of the employee's personal property if he or she were to die intestate will apply. If such laws would permit the claimant to inherit the employee's personal property, the claimant will be considered the child of the employee. The state inheritance laws where the employee was domiciled when he or she died will apply. If the employee's domicile was not in one of the 50 states, the Commonwealth of Puerto Rico, the Virgin slands, Guam, American Samoa, or the Northern Mariana Islands, the laws of the District of Columbia will apply.

(2) *Standards.* The Board will not apply any state inheritance law requirement that an action to establish paternity must have been commenced within a specific time period, measured from the employee's death or the child's birth, or that an action to establish paternity must have been commenced or completed before the employee's death. If state laws on inheritance require a court to determine paternity, the Board will not require such a determination, but the Board will decide paternity using the standard of proof that the state court would apply as the basis for making such a determination.

(3) *Employee is living.* If the employee is living, the Board will apply the state law where the employee is domiciled which was in effect when the annuity may first be increased under the social security overall minimum (see part 229 of this chapter). If under a version of state law in effect at that time, a person does not qualify as a child of the employee, the Board will look to all versions of state law in effect from when the employee's annuity may first have been increased until the Board makes a final decision, and will apply the version of state law most favorable to the employee.

(4) *Employee is deceased.* The Board will apply the state law where the employee was domiciled when he or she died. The Board will apply the version of state law in effect at the time of the final decision on the application for benefits. If under that version of state law the claimant does not qualify as the child of the employee, the Board will apply the state law in effect when the employee died, or any version of state law in effect from the month of potential entitlement to benefits until a final determination on the application. The Board will apply the version most beneficial to the claimant. The following rules determine the law in effect as of the employee's death:

(i) Any law enacted after the employee's death, if that law would have retroactive application to the employee's date of death, will apply; or

(ii) Any law that supersedes a law declared unconstitutional, that was considered constitutional on the employee's date of death, will apply.

[65 FR 20726, Apr. 18, 2000]

§ 222.33 Relationship resulting from legal adoption.

(a) *Adopted by employee.* A claimant will be considered to be the child of the employee for both annuity and lump-sum payment purposes if the employee legally adopted the claimant in accordance with applicable State law. Legal adoption differs from equitable adoption in that in the case of legal adoption formal adoption proceedings have been completed in accordance with applicable State law and such proceedings are not defective.

(b) *Adopted by widow or widower.* A claimant who is legally adopted by the widow or widower of the employee after the employee's death will be considered to be the child of the employee for annuity but not for lump-sum payment purposes if—

(1) Either the claimant is adopted by the widow or widower within two years after the date on which the employee died, or the employee commenced proceedings to legally adopt the claimant before the employee's death; and

(2) The claimant was living in the employee's household at the time of the employee's death; and

(3) The claimant was not receiving regular support contributions from any other person other than the employee or spouse at the time of the employee's death.

(c) The adoption laws of the state or foreign country where the adoption took place, not the state inheritance laws, will determine whether the claimant is the employee's adopted child.

[54 FR 42949, Oct. 19, 1989, as amended at 65 FR 20727, Apr. 18, 2000]

§ 222.34 Relationship resulting from equitable adoption.

In many States, where a legal adoption proceeding was defective under State law or where a contemplated legal adoption was not completed, a claimant may be considered to be an equitably adopted child. A claimant will have the relationship of an equitably adopted child for annuity and lump-sum payment purposes if, in addition to meeting the other requirements of this part—

(a) The employee had agreed to adopt the claimant; and

(b) The natural parents or the person legally responsible for the care of the claimant agreed to the adoption; and

(c) The employee and the claimant lived together as parent and child; and

(d) The agreement to adopt is recognized under applicable State law such that, if the employee were to die without leaving a will, the claimant could inherit a share of the employee's personal estate as the child of the employee.

§ 222.35 Relationship as stepchild.

A claimant will be considered to have the relationship of stepchild of an employee, and will be considered a child for annuity but not for lump-sum benefit purposes if—

(a) The claimant's natural or adoptive parent married the employee after the claimant's birth; and

(b) The marriage between the employee and the claimant's parent is a valid marriage under applicable State law (see §§ 222.12 and 222.13), or would be valid except for a legal impediment; and

(c) The employee and the claimant's parent were married at least one year before the date—

(1) On which the spouse applies for an annuity based on having the employee's child in care; or

(2) On which the employee's annuity can be increased under the social security overall minimum provision; or

(d) The employee and the claimant's parent were married at least nine months before the date on which the employee died if the claimant is applying for a child's annuity; or if the employee and the claimant's parent were married less than nine months, the employee was reasonably expected to live for nine months, and—

(1) The employee's death was accidental; or

(2) The employee died in the line of duty as a member of the armed forces of the United States; or

(3) The widow(er) was previously married to the employee for at least nine months.

§ 222.36 Relationship as grandchild or stepgrandchild.

A claimant will have the relationship of grandchild or stepgrandchild of an employee, or the grandchild or stepgrandchild of an employee's spouse, and be considered a child for annuity purposes if the requirements in both paragraph (a) and either paragraph (b) or (c) of this section are met.

(a) The claimant is the natural child, adopted child, or stepchild of a child of an employee, or of a child of the employee's spouse as defined in this subpart;

(b) The claimant's natural or adoptive parents are deceased or are disabled, as defined in section 223(d) of the Social Security Act, in the month in which—

(1) The employee, who is entitled to an age and service or disability annuity, under the Railroad Retirement Act, would also be entitled to an age benefit under section 202(a) of the Social Security Act or a disability benefit under section 223 of the Social Security Act, if his or her railroad compensation were considered wages under that Act; or

(2) The employee dies; or

(3) The employee's period of disability begins, if the employee has a period of disability which continues until he or she could be entitled to a social security benefit as described in paragraph (b)(1) of this section or until he or she dies.

(c) The claimant was legally adopted in the United States by the employee's widow(er) after the employee's death, and the claimant's natural or adoptive parent or stepparent was not living in the employee's household and making regular contributions to the claimant's support at the time the employee died.

NOTE: A grandchild or stepgrandchild does not have the relationship of ''child'' for lump-sum payment purposes (see § 222.44).

Subpart E—Relationship as Parent, Grandchild, Brother or Sister

§ 222.40 When determinations of relationship are made for parent, grandchild, brother or sister.

(a) *Parent.* The claimant's relationship as a parent of the employee is determined when the claimant applies for an annuity or for lump-sum payments.

(b) *Grandchild.* The claimant's relationship as a grandchild, rather than as a child, of the employee is determined when the claimant applies for lump-sum payments.

(c) *Brother or sister.* The claimant's relationship as a brother or sister of the employee is determined when the claimant applies for lump-sum payments.

§ 222.41 Determination of relationship and support for parent.

(a) *Annuity claimant.* For purposes of applying for an annuity, a claimant is considered the employee's parent when the claimant—

(1) Is the natural mother or father of the employee, and is considered the employee's parent under the law of the State in which the employee had a permanent home when the employee died; or

(2) Is a person who legally adopted the employee before the employee became 16 years old; or

(3) Is a stepparent who married the employee's natural or adoptive parent before the employee became 16 years old (the marriage must be valid under the law of the State in which the employee had a permanent home when the employee died); and

(4) Was receiving at least one-half support from the employee (see §§ 222.42 and 222.43 of this part) either when the employee died or at the beginning of the period of disability, if the employee had a period of disability.

(b) *Lump-sum payment claimant.* For purposes of applying for lump-sum payments, a claimant is considered the employee's parent when he or she—

(1) Is the natural mother or father of the employee, and is considered the employee's parent under applicable State law; or

(2) Legally adopted the employee, if thereby recognized as a parent under applicable State law; but

(3) The claimant need not have received one-half support from the employee.

§ 222.42 When employee is contributing to support.

(a) An employee is contributing to the support of a person if the employee gives cash, goods, or services to help support such person. Support includes food, clothing, housing, routine medical care, and other ordinary and necessary living expenses. The value of any goods which the employee contributes shall be based upon the replacement cost of those goods at the time they are contributed. If the employee provides services that would otherwise require monetary payment, the cash value of the employee's services may be considered a contribution to support.

(b) The employee is contributing to the support of a person if that person receives an allotment, allowance, or benefit based upon the employee's military pay, veteran's pension or compensation, social security earnings, or railroad compensation.

(c) Contributions must be made regularly and must be large enough to meet an important part of the person's ordinary and necessary living expenses. If the employee provides only occasional gifts or donations for special purposes, they will not be considered contributions for support. Although the employee's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the employee's control, such as illness or unemployment, will be disregarded unless during these interruptions someone else assumes responsibility for support of the person on a regular basis.

§ 222.43 How the one-half support determination is made.

(a) *Amount of contributions.* The employee provides one-half support to a person if the employee makes regular contributions to that person's support, and the amount of the contributions is equal to or in excess of one-half of the person's ordinary and necessary living expenses. Ordinary and necessary living expenses are the costs for food, clothing, housing, routine medical care, and similar necessities. A contribution may be in cash, goods, or services (see § 222.42 of this part). For example, an employee pays rent and utilities amounting to $6,000 per year on an apartment in which his mother resides. In addition, the employee's mother receives $3,600 per year in social security benefits which she uses to pay for her food, clothing and medical care. The mother's total necessary living expenses are $9,600 ($6,000 + $3,600). Since the employee contributes $6,000 toward these expenses, he is contributing in excess of one-half of his mother's support.

(b) *Reasonable period of time.* The employee is not providing at least one-half of a person's support unless the employee has made contributions for a reasonable period of time. Ordinarily, the Board will consider a reasonable period of time to be the 12-month period immediately preceding the time when the one-half support requirement must be satisfied. However, if the employee provided one-half or more of the person's support for at least 3 months of the 12-month period, and was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over responsibility for providing at least one-half of the person's support on a permanent basis, three months shall be considered a reasonable period of time.

§ 222.44 Other relationship determinations for lump-sum payments.

Other claimants will be considered to have the relationships to the employee shown below for lump-sum payment purposes:

(a) *Grandchildren.* A grandchild is a separate class of beneficiary to be considered for lump-sum payments and is not a child of the employee; he or she is a child of the employee's son or daughter as determined under State law. A stepgrandchild is not included in this class of beneficiary.

(b) *Brother or Sister.* ''Brother'' or ''Sister'' means a full brother or sister or a half brother or half sister, but not a stepbrother or stepsister.

Subpart F—Child Support and Dependency

§ 222.50 When child dependency determinations are made.

(a) *Dependency determination.* One of the requirements for a child's annuity or for increasing an employee or spouse annuity under the social security overall minimum provision on the basis of the presence of a child in the family group is that the child be dependent upon the employee. The dependency requirements and the time when they must be met are explained in §§ 222.51 through 222.57.

(b) *Related determinations.* To prove a child's dependency, an applicant may be asked to show that at a specific time the child lived with the employee, that the child received contributions for his or her support from the employee, or that the employee provided at least one-half of the child's support. The terms ''living with'', ''contributing to support'', and ''one-half support'' are defined in §§ 222.58, 222.42, an 222.43. These determinations are required when—

(1) A natural child or legally adopted child of the employee is adopted by someone else; or

(2) The child claimant is the stepchild, grandchild, or equitably adopted child of the employee.

§ 222.51 When a natural child is dependent.

The employee's natural child, as defined in § 222.32, is considered to be dependent upon the employee. However, if the child is legally adopted by someone else during the employee's lifetime and, after the adoption, a child's annuity or other annuity or annuity increase is applied for on the basis of the employee's earnings record and the relationship of the child to the employee, the child will be considered dependent upon the employee (the natural parent) only if he or she was either living with the employee or the employee was contributing to the child's support when either:

(a) A spouse's annuity begins; or

(b) The employee's annuity can be increased under the social security overall minimum provision; or

(c) The employee dies; or

(d) If the employee had a period of disability which lasted until he or she could have become entitled to an age or disability benefit under the Social Security Act (treating the employee's railroad compensation as wages under that Act), at the beginning of the period of disability or at the time the employee could have become entitled to the benefit.

§ 222.52 When a legally adopted child is dependent—general.

(a) *During employee's lifetime.* If the employee adopts a child before he or she could become entitled to a social security benefit (treating his or her railroad compensation as wages under that Act), the child is considered dependent upon the employee. If the employee adopts a child, unless the child is his natural child or stepchild, after he or she could become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under that Act), the child is considered dependent on the employee only if the requirements of § 222.53 are met.

(b) *After employee's death.* If the surviving spouse of an employee adopted a child after the employee's death, the child is considered dependent on the employee if either—

(1) The employee began proceedings to adopt the child prior to his or her death, or the surviving spouse adopted the child within two years after the employee's death; and

(2) The child was living in the employee's household at the time of the employee's death; and

(3) The child was not receiving regular contributions from any person, including any public or private welfare organization, other than the employee or spouse at the time of the employee's death.

§ 222.53 When a legally adopted child is dependent—child adopted after entitlement.

A child who is not the employee's natural child, stepchild, grandchild, or stepgrandchild, and who is adopted by the employee after the employee could become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad

compensation as wages under that Act), is considered dependent on the employee during the employee's lifetime only if the requirements in paragraphs (a) and (b), and either (c) or (d) of this section are met:

(a) The child is adopted in the United States;

(b) The child began living with the employee before the child attained age 18;

(c) The child is living with the employee in the United States and received at least one-half of his or her support from the employee for the year before the month in which—

(1) The employee could become entitled to a social security benefit as described above; or

(2) The employee becomes entitled to a period of disability which continues until he or she could become entitled to a social security benefit as described above.

(d) In the case of a child born within the one-year period stated in paragraph (c) of this section, at the close of such period the child must have been living with and have been receiving at least one-half of his or her support from the employee for substantially all of the period that began on the date the child was born.

(e) ''Substantially all'' means—

(1) The child was living with and receiving one-half support from the employee when the employee could have become entitled to a social security benefit as described above; and

(2) Any period during which the child was not living with or receiving one-half support from the employee is not more than one-half the period from the child's birth to the employee's date of entitlement or three months, whichever is less.

§ 222.54 When a legally adopted child is dependent—grandchild or stepgrandchild adopted after entitlement.

If an employee legally adopts his or her grandchild or the spouse's grandchild after he could become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under that Act), the grandchild is considered dependent on the employee during the employee's lifetime only if the requirements in paragraphs (a) and (b), and either (c) or (d) of this section are met:

(a) The grandchild is adopted in the United States.

(b) The grandchild began living with the employee before the grandchild attained age 18.

(c) The grandchild is living with the employee in the United States and receives at least one-half of his or her support from the employee for the year before the month in which—

(1) The employee's annuity was increased under the social security overall minimum provision by including the grandchild; or

(2) The employee could become entitled to a social security benefit as described above; or

(3) The employee becomes entitled to a period of disability which continues until he or she could become entitled to a social security benefit as described above.

(d) In the case of a grandchild born within the one-year period referred to in paragraph (c) of this section, at the close of such period the child must have been living with and have been receiving at least one-half of his or her support from the employee for substantially all of the period that began on the date the grandchild was born. ''Substantially all'' is defined in § 222.53.

§ 222.55 When a stepchild is dependent.

An employee's stepchild, as described in § 222.35, is considered dependent on the employee if the stepchild receiving at least one-half of his or her support from the employee at one of the times shown in § 222.51.

[54 FR 42949, Oct. 19, 1989, as amended at 62 FR 47138, Sept. 8, 1997]

§ 222.56 When a grandchild or stepgrandchild is dependent.

An employee's grandchild or stepgrandchild, as described in § 222.36, is considered dependent on the employee if the requirements in both paragraphs (a) and (b), or paragraph (c) of this section are met:

(a) The grandchild or stepgrandchild was living with the employee before

the grandchild or stepgrandchild attained age 18.

(b) The grandchild or stepgrandchild is living with the employee in the United States and receives at least one-half of his or her support from the employee for the year before the month in which—

(1) The employee could become entitled to an age and service or disability annuity under the Social Security Act (treating his or her railroad compensation as wages under that Act); or

(2) The employee dies; or

(3) The employee becomes entitled to a period of disability that lasts until he or she could become entitled to a social security benefit as described above or until he or she dies.

(c) In the case of a grandchild or stepgrandchild born within the one-year period referred to in paragraph (b) of this section, at the close of such period the child must have been living with and receiving at least one-half of his or her support from the employee for substantially all of the period that began on the date the grandchild or stepgrandchild was born. ''Substantially all'' is defined in § 222.53.

§ 222.57 When an equitably adopted child is dependent.

An employee's equitably adopted child, as defined in § 222.34, is considered dependent upon the employee if the employee was either living with or contributing to the support of the child at the time of his or her death. If the equitable adoption is found to have occurred after the employee could have become entitled to an old age or disability benefit under the Social Security Act (treating his or her railroad compensation as wages under that Act), the child is not considered dependent on the employee during the employee's lifetime. If the equitable adoption took place before such time, the child is dependent on the employee if the employee was living with or contributing to the support of the child at one of the times shown in § 222.51.

§ 222.58 When a child is living with an employee.

A child is living with the employee if the child normally lives in the same household with the employee and the employee has parental control and authority over the child's activities. The child is considered to be ''living with'' the employee while they are living apart if they expect to live together again after a temporary separation. A temporary separation may include the employee's absence because of working away from home or hospitalization. However, the employee must have parental control and authority over the child during the period of temporary separation. A child who is in active military service or in prison is not ''living with'' the employee, since the employee does not have parental control over the child.

PART 225—PRIMARY INSURANCE AMOUNT DETERMINATIONS

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Subpart A—General

§ 225.1 Introduction.

This part discusses Primary Insurance Amount, which is referred to as PIA throughout this part, and which is an important element in the calculation of any retirement or survivor annuity. There are a number of PIA computations based on different periods, amounts, and types of earnings. However, the formulas for computing any PIA are prescribed in section 215 of the Social Security Act and are described in detail in the regulations of the Social Security Administration (20 CFR part 404, subpart C). This part discusses PIA computation formulas and relates them to the PIA's which the Board uses. Descriptions of the majority of PIA's used in computing retirement or survivor annuities under the Railroad Retirement Act are contained in this part. Explanations are included of when delayed retirement credits and cost-of-living increases can be added to the PIA's used by the Board. This part also explains when and how a PIA is recomputed or adjusted. Since these regulations are intended to address annuities currently being awarded, certain PIA's, not used in the computation of annuities awarded after August 13, 1981, are not included in these regulations. Parts 226, 228 and 229 of this chapter explain how PIA's are used in actual annuity computations.

§ 225.2 Definitions.

As used in this part:

Average Indexed Monthly Earnings means the result of dividing the total of the indexed earnings through the indexing year and the nonindexed earnings after the indexing year in the benefit computation years by the number of months in the benefit computation years. The indexing year for the Average Indexed Monthly Earnings PIA is the second year before the employee's eligibility year. Indexing of an employee's yearly earnings serves to put the earnings in proportion to the earnings level of all workers for the corresponding years, and to express the earnings in terms of a more recent dollar value. Indexed earnings are determined under section 215(b)(1) of the Social Security Act. The Average Indexed Monthly Earnings formula PIA is based on the Average Indexed Monthly Earnings amount.

Average Monthly Earnings means the average determined by dividing the acutal earnings used in computing the PIA by the total months in the benefit computation years. The Average Monthly Earnings is determined under section 215(b)(4) of the Social Security Act. The Average Monthly Earnings formula PIA is based on the Average Monthly Earnings amount.

Base Years means the years after 1950 (or 1936, if applicable) and up to the year in which the employee dies or is

entitled to an annuity based on retirement or disability. When the employee's death occurs before he or she reaches retirement age as defined in section 216(l) of the Social Security Act, the Base Years include the year of the employee's death. Base Years are defined in sections 215(b)(2)(B)(ii) and 215(d) of the Social Security Act.

Benefit Computation Years means the years with the highest earnings used in computing the Average Indexed Monthly Earnings or Average Monthly Earnings. The number of Benefit Computation Years is determined in accordance with section 215(b)(2)(B)(i) of the Social Security Act and is based on the employee's age or when the employee becomes disabled or dies.

Compensation means *railroad compensation* which is the amount of creditable railroad earnings under the Railroad Retirement Act, as explained in part 211 of this chapter.

Earnings means *compensation* creditable under the Railroad Retirement Act (other than compensation attributable to years of service prior to 1937) or ''wages'' creditable under the Social Security Act or both.

Eligible means that a person meets the necessary requirements and could qualify for payment if a valid application were filed.

Eligibility Year means the earliest of: the employee's year of attainment of age 62; The year of disability onset; or the year of death. The Eligibility Year determines the formula used to compute a Primary Insurance Amount. Eligibility Year is defined in section 215(a) of the Social Security Act.

Employee means any person who is working or has worked for a railroad employer who is eligible for a retirement annuity or on whose account a survivor is eligible for a survivor annuity, as explained in part 216 of this chapter. For a detailed discussion of Employees under the Railroad Retirement Act, see part 203 of this chapter.

Entitled means that a person meets the necessary requirements, files a valid application and establishes his or her right to payment.

Indexed Earnings means the employee's yearly earnings for the years after 1950 that have been adjusted to put the earnings in proportion to the earnings level of all workers for each of those years and to express the earnings in terms of a more recent dollar amount.

Primary Insurance Amount (PIA) means the result obtained by applying one of three formulas in the Social Security Act to the employee's earnings as prescribed under that Act. A PIA can be based on the Average Indexed Monthly Earnings formula, the Average Monthly Earnings formula or, in the case of the Special Minimum PIA, on a special formula based on years of coverage. Averaging earnings and PIA formulas are prescribed in section 215 of the Social Security Act.

Social Security Act means the Social Security Act as amended from time to time, unless the Act as in effect on a particular date is specified.

Wages means creditable wages or self-employment under sections 209 or 211, respectively, of the Social Security Act.

Year of service means 12 months of railroad service credited in accordance with part 210 of this chapter.

Years of coverage means years after 1936 as defined in section 215(a)(1)(C)(ii) of the Social Security Act in which the employee had earnings over certain specified amounts. Years of Coverage is primarily a factor in determining the Special Minimum formula PIA amount.

[54 FR 12903, Mar. 29, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 225.3 PIA computation formulas.

(a) *General.* PIA's are generally computed under one of two normal formulas determined by the employee's eligibility year. In addition, there is a special PIA formula, based on an employee's years of coverage, that is used when it produces a PIA that is higher than the PIA computed under the appropriate PIA formula. The two most common PIA formulas are the Average Indexed Monthly Earnings PIA formula and the Average Monthly Earnings PIA formula. The special PIA formula is called the Special Minimum PIA formula.

(b) *Average Indexed Monthly Earnings PIA formula.* When the employee's eligibility year is after 1978, the Tier I PIA, Overall Minimum PIA, Survivor

Tier I PIA, Employee's Retirement Insurance Benefit PIA and Residual Lump-Sum PIA are computed under the Average Indexed Monthly Earnings PIA formula.

(c) *Average Monthly Earnings PIA formula.* The Average Monthly Earnings PIA formula is used to compute a PIA for one of two reasons: either the employee's eligibility year is before 1979 or the type of PIA requires that it always be computed under the Average Monthly Earnings PIA formula.

(1) *Use of Average Monthly Earnings PIA formula based on the employee's eligibility year.* The Average Monthly Earnings PIA formula is used in computing the Tier I PIA, the Overall Minimum PIA, the Employee Fictional Retirement Insurance Benefit PIA and the Residual Lump-Sum PIA when the employee's eligibility year is before 1979.

(2) *Types of PIA's always computed using the Average Monthly Earnings PIA formula.* The following PIA's used by the Board are determined under the Social Security Act as in effect on December 31, 1974, and are always computed using the Average Monthly Earnings PIA formula.

(i) Combined Earnings Dual Benefit PIA described in § 225.12.

(ii) Social Security Earnings Dual Benefit PIA described in § 225.13.

(iii) Railroad Earnings Dual Benefit PIA described in § 225.14.

(iv) Combined Earnings PIA described in § 225.23.

(v) Social Security Earnings PIA described in § 225.24.

(vi) Railroad Earnings PIA described in § 225.25.

(d) *Special Minimum PIA formula.* The Special Minimum PIA formula is based on the employee's years of coverage. The Special Minimum PIA formula usually applies when the employee had consistently low earnings during his or her working lifetime. The Special Minimum PIA formula is used when it is higher than the PIA calculated under the applicable Average Indexed Monthly Earnings formula or the Average Monthly Earnings formula.

§ 225.4 Limitation on amount of earnings used to compute a PIA.

Certain PIA's used by the Board are based on a combination of compensation and wages, while other PIA's used by the Board are based solely on either compensation or wages. For purposes of crediting earnings when computing any PIA, compensation is always treated as wages. Regardless of whether a PIA is based on a combination of compensation and wages or exclusively on either compensation or wages, the total earnings for each year used in computing a PIA cannot be higher than the maximum social security earnings creditable in that year under sections 209(a) and 211(b) of the Social Security Act. The various PIA's used by the Board are described in subparts B and C of this part.

Subpart B—PIA's Used in Computing Employee, Spouse and Divorced Spouse Annuities

§ 225.10 General.

This subpart contains information about the PIA's that can be used in computing most employee, spouse and divorced spouse annuities. The Tier I PIA is used in computing the tier I component of an employee, spouse or divorced spouse annuity. The Combined Earnings Dual Benefit PIA, Social Security Earnings Dual Benefit PIA and Railroad Earnings Dual Benefit PIA are used in computing an employee's vested dual benefit component and a corresponding tier II component offset when entitlement to a vested dual benefit exists. Retirement annuity computations are discussed in part 226 of this chapter. The Overall Minimum PIA is used in computing the overall minimum guaranty formula rate as discussed in part 229 of this chapter.

§ 225.11 Tier I PIA.

(a) *General.* The Tier I PIA is used in computing an employee, spouse or divorced spouse tier I amount. Except for the cases described in paragraphs (b) through (d) of this section, a Tier I PIA is determined under sections 215 and 223 of the Social Security Act. Railroad

and Social Security earnings are included in the calculation of a Tier I PIA.

(b) *Employee attains age 60 and/or acquires 30 years of service after June 30, 1984.* When an employee is entitled to an age and service annuity before the month of attaining age 62, as explained in part 216 of this chapter, the following Railroad Retirement Act rules apply in addition to those in §225.11(a) in computing the Tier I PIA.

(1) Four months before the first full month the employee is age 62, the Average Indexed Monthly Earnings is determined as if the employee's eligibility year were the year the annuity began.

(2) The benefit computation years used in computing the Tier I PIA are based on the date of the employee's actual attainment of age 62.

(3) The Tier I PIA is adjusted when the employee reaches age 62 to use the year in which the employee attains age 62 as the eligibility year.

(4) Cost-of-living increases and recomputations apply after the employee attains age 62.

(c) *Employee attains age 60 and acquires 30 years of service before July 1, 1984.* For purposes of determining the benefit computation years to be used in computing the Tier I PIA for an employee who is age 60 through 64, and who both has 30 years of service and attains age 60 prior to July 1, 1984, the employee is considered to be age 65 when the age and service annuity begins. For purposes of computing the Average Indexed Monthly Earnings, the eligibility year is the year the annuity begins or age 62, if earlier. Cost-of-living increases are paid from the year the annuity begins. Recomputations are paid after the employee actually attain age 62.

(d) *Disability annuity.* When an employee is entitled to a disability annuity, as explained in subpart B of part 216 of this chapter, the following Railroad Retirement Act rule applies in addition to those in §225.11(a) in computing the Tier I PIA. The Tier I PIA is computed as if the employee were 62 years old on the date, as determined by the Board, of onset of disability, if the employee is under age 62 on that date.

§ 225.12 Combined Earnings Dual Benefit PIA.

(a) *General.* The Combined Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Combined Earnings Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Railroad and social security earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Railroad and social security earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Combined Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and had a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Railroad and social security earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in railroad service are used in computing the Combined Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.13 Social Security Earnings Dual Benefit PIA.

(a) *General.* The Social Security Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Social Security Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Social security earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Social security earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Social Security Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and has a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Social security earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in the railroad industry are used in computing the Social Security Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.14 Railroad Earnings Dual Benefit PIA.

(a) *General.* The Railroad Earnings Dual Benefit PIA is used in computing the employee vested dual benefit when the employee meets certain eligibility requirements as described in part 216 of this chapter. The Railroad Earnings Dual Benefit PIA is also used in computing the employee's tier II annuity component when the employee becomes entitled to a vested dual benefit. This PIA is determined under section 215 of the Social Security Act as in effect on December 31, 1974. Railroad earnings after 1950 (or after 1936, if applicable) and through December 31, 1974, or the last year of railroad service before 1974 are included in the calculation of this PIA.

(b) *Employee insured on own wage record on December 31, 1974.* Railroad earnings after 1950 (or after 1936, if a higher PIA would result) and through 1974 are used in computing the Railroad Earnings Dual Benefit PIA if the employee—

(1) Had at least 25 years of railroad service before January 1, 1975; or

(2) Had at least 10 years of railroad service as of December 31, 1974, and worked in the railroad industry anytime during calendar year 1974; or

(3) Had at least 10 years of railroad service as of December 31, 1974, and had a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

(c) *Employee insured on own wage record in last year of railroad service.* Railroad earnings after 1950 (or after 1936, if a higher PIA would result) and through December 31 of the year before 1974 in which the employee last worked in railroad service are used in computing the Railroad Earnings Dual Benefit PIA if the employee—

(1) Had at least 10 but less than 25 years of railroad service through December 31, 1974; and

(2) Did not work in the railroad industry during 1974; and

(3) Did not have a current connection with the railroad industry (as described in part 216 of this chapter) on December 31, 1974, or when the employee annuity began.

§ 225.15 Overall Minimum PIA.

The Overall Minimum PIA is considered when the employee would be eligible for an old age insurance benefit or a disability insurance benefit under section 202 or 223 of the Social Security Act based on combined railroad and social security earnings. The Overall Minimum PIA is used in computing the social security overall minimum guaranty amount. The overall minimum guaranty rate annuity formula is discussed in part 229 of this chapter. The Overall Minimum PIA is determined under the rules in sections 215 and 223 of the Social Security Act. Railroad and social security earnings are included in the calculation of the Overall Minimum PIA. The Overall Minimum PIA is used to determine the amount which is treated as a social security benefit for the purpose of taxation pursuant to section 86(d) of the Internal Revenue Code of 1986.

Subpart C—PIA's Used in Computing Survivor Annuities and the Amount of the Residual Lump-Sum Payable

§ 225.20 General.

The Survivor Tier I PIA and the Employee RIB PIA are used in computing the tier I component of a survivor annuity. The Combined Earnings PIA, Social Security Earnings PIA and Railroad Earnings PIA may be used in computing a vested dual benefit offset in the survivor tier II component when the survivor tier II is based on a percentage of the employee annuity tier II. In addition, these three PIA's are identical to those dual benefit PIA's used in computing an employee retirement annuity, as described in subpart B of this part, when the employee died after being entitled to an annuity. Survivor annuity computations are discussed in part 228 of this chapter. The Residual Lump-Sum PIA (RLS PIA) is used in computing the amount of the residual lump-sum payable when retirement annuity payments were made, as explained in part 234 of this chapter.

§ 225.21 Survivor Tier I PIA.

The Survivor Tier I PIA is used in computing the tier I component of a survivor annuity. This PIA is determined in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings after 1950 (or after 1936 if a higher PIA would result) through the date of the employee's death.

§ 225.22 Employee RIB PIA used in survivor annuities.

The Employee Retirement Insurance Benefit PIA (Employee RIB PIA) is used to compute the employee RIB amount when the employee had received a retirement annuity which was reduced for early retirement. As explained in part 228 of this chapter, the employee RIB amount may be used in the survivor tier I component. This PIA is computed in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings. The Employee RIB PIA is the same as the Survivor Tier I PIA when the employee had no earnings in the year of death. Earnings in the year of death are used in the recomputed PIA beginning January 1 of the year after the employee's death. (See subpart F of this part for a discussion of PIA recomputations.)

§ 225.23 Combined Earnings PIA used in survivor annuities.

The Combined Earnings PIA used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement Combined Earnings Dual Benefit PIA described in subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The Combined Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's combined railroad and social security earnings after

1950 (or after 1936 if a higher PIA would result) through December 31, 1974.

§ 225.24 SS Earnings PIA used in survivor annuities.

The Social Security Earnings PIA (SS Earnings PIA) used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement SS Earnings Dual Benefit PIA described in subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The SS Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's social security earnings after 1950 (or after 1936, if a higher PIA would result) through December 31, 1974.

§ 225.25 RR Earnings PIA used in survivor annuities.

The Railroad Earnings PIA (RR Earnings PIA) used in survivor annuities may be used in computing the tier II component when the survivor tier II is based on a percentage of the employee annuity tier II and the employee had been or would be, if he or she were still alive, entitled to a vested dual benefit. If the employee received a retirement annuity before death, this PIA is identical to the retirement RR Earnings Dual Benefit PIA described in Subpart B of this part. If a retirement annuity was not paid before the employee's death, the PIA is determined as if the employee were 65 years old in the month of his or her death. The RR Earnings PIA used in survivor annuities is determined in accordance with section 215 of the Social Security Act as in effect on December 31, 1974. It is computed using the deceased employee's railroad earnings after 1950 (or after 1936, if a higher PIA would result) through December 31, 1974.

§ 225.26 Residual Lump-Sum PIA.

The Residual Lump-Sum PIA (RLS PIA) is used to compute the regular retirement annuity amounts to be deducted from the gross residual lump-sum amount in determining the amount of the residual lump-sum payable, as explained in Part 234 of this chapter. The RLS PIA is determined in accordance with section 215 of the Social Security Act using the employee's railroad compensation after 1950 (or after 1936, if a higher PIA would result) as if it were social security earnings. The RLS PIA is computed just like the retirement Tier I PIA described in Subpart B of this part, except that social security earnings are not used to compute the RLS PIA.

Subpart D—Delayed Retirement Credits

§ 225.30 General.

(a) A delayed retirement credit (DRC) is a percentage increase in a PIA. An employee who would have an insured status in accordance with section 214(a) of the Social Security Act based on combined railroad and social security earnings can earn DRC's. A DRC can be earned by the employee for each month, in or after the month of attaining full retirment age and before the month of attaining age 70 (72 before 1984), in which the employee does not receive either—

(1) An annuity because the employee did not apply for an annuity; or

(2) The tier I and vested dual benefit work deduction annuity components or the social security overall minimum annuity rate because they are not paid since the employee works and has earnings in excess of the exempt amount. (The tier I and vested dual benefit work deduction annuity components, the social security overall minimum annuity rate and the exempt amount are described in parts 226, 229 and 230 of this chapter, respectively.)

(b) Any credit earned by the employee also extends to the employee's widow(er), remarried widow(er) or surviving divorced spouse when he or she receives a survivor annuity that is based on age or disability.

(c) Credit earned by the employee does not extend to the employee's spouse or divorced spouse.

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§ 225.31 PIA's to which DRC's are added.

(a) DRC's can be added to the following PIA's when used in computing the following benefits:

(1) Tier I PIA used in computing a retirement employee annuity.

(2) Overall Minimum PIA used in computing a retirement employee annuity.

(3) Survivor Tier I PIA used in computing a widow(er), remarried widow(er) or surviving divorced spouse annuity based on age or disability.

(4) Employee RIB PIA used in computing a widow(er), remarried widow(er) or surviving divorced spouse annuity based on age or disability.

(5) RLS PIA used in computing the amount of the residual lump-sum payable (as explained in part 234 of this chapter).

§ 225.32 DRC's and the Special Minimum PIA.

Delayed retirement credits cannot be added to the Special Minimum PIA. Delayed retirement credits can only be added to the regular PIA's used in computing the benefits outlined in § 225.31.

§ 225.33 Months for which DRC's are due.

(a) A DRC is due for each month after 1970 in which the employee is—

(1) Full retirement age or older and under age 70 (72 before 1984); and

(2) Fully insured under section 214(a) of the Social Security Act based on combined railroad and social security earnings; and either—

(i) Is not entitled to an annuity because he or she did not apply for an annuity; or

(ii) Is entitled to an annuity but has the full amount of the tier I and vested dual benefit work deduction component (described in part 226 of this chapter) or the social security overall minimum rate (described in part 229 of this chapter) withheld because of earnings in excess of the exempt amount (as explained in part 230 of this chapter).

(b) The months for which credit is due need not be consecutive.

[54 FR 12903, Mar. 29, 1989, as amended at 68 FR 39010, July 1, 2003]

§ 225.34 How the amount of the DRC is figured.

(a) The amount of the DRC depends on—

(1) The year the employee reaches full retirement age; and

(2) The number of months for which the credit is due, as explained in § 225.33.

(b) The percent given in paragraph (b)(1), (2), or (3) of this section is multiplied by the PIA; that product is then multiplied by the number of months for which credit is due and rounded to the next lowest multiple of $0.10, if the answer is not already a multiple of $0.10. The result is the DRC which is added to the PIA.

(1) *Employee attained age 65 before 1982.* The DRC equals one-twelfth of one percent of the PIA times the number of months after 1970 in which the employee is age 65 or older and for which credit is due.

(2) *Employee attains age 65 after 1981 and before 1990.* The DRC equals one-fourth of one percent of the PIA times the number of months in which the employee is age 65 or older and for which credit is due.

(3) Employee attains age 65 in 1990 and before 2003.

(i) The rate of the DRC (one-fourth of one percent) is increased by one-twenty-fourth of one percent in each even year through 2002. Therefore, depending on when the employee attains age 65, the DRC percent will be as follows:

Year employee attains age 65	Delayed retirement credit percent
1990	7/24 of 1%.
1991	Do.
1992	1/3 of 1%.
1993	Do.
1994	3/8 of 1%.
1995	Do.
1996	5/12 of 1%.
1997	Do.
1998	11/24 of 1%.
1999	Do.
2000	1/2 of 1%.
2001	Do.
2002	13/24 of 1%.

(ii) The delayed retirement credit equals the appropriate percent of the PIA times the number of months in which the employee is age 65 or older and for which credit is due.

(4) Employee attains full retirement age in 2003 or later. The rate of the DRC (one-fourth of one percent) is increased by one-twenty-fourth of one percent in each even year through 2008. Therefore, depending on when the employee attains full retirement age, the DRC percent will be as follows:

Year employee attains full retirement age	Delayed retirement credit percent
2003	13/24 of 1%.
2004	7/12 of 1%.
2005	Do.
2006	5/8 of 1%.
2007	Do.
2008 and later	2/3 of 1%.

(c) *Example:* Mr. Jones was qualified for a full age and service annuity when he reached age 65 in January 1985, but decided not to apply for an annuity because he was still working. Mr. Jones stopped working on December 31, 1985, and applied for his annuity to begin January 1, 1986. Based on his earnings, his PIA was $350.50. Since Mr. Jones did not receive an annuity for the 12 months from the month in which he became 65 (January 1985) until the month following the month he stopped working (January 1986), he is due credit for each of those 12 months. The total amount of his DRC's is calculated as follows:

Percent		PIA		No. of months		Unrounded result		Total amount of DRC's
.25%	X	350.50	X	12	=	10.51	=	$10.50

Mr. Jones' PIA increase for DRC's is $361.00 (350.50 + 10.50).

[54 FR 12903, Mar. 29, 1989; 54 FR 21203, May 17, 1989; 68 FR 39010, July 1, 2003; 68 FR 43515, Aug. 1, 2003]

§ 225.35 When a PIA used in computing a retirement annuity can be increased for DRC's.

Delayed retirement credits earned at different times are added to the PIA used in computing a retirement annuity as follows:

DRC's earned for month in	Are added to PIA
Years before the year the employee annuity begins.	On the date the annuity begins.
Year the annuity begins	On January 1 of the year after the annuity begins.
Years after the annuity begins, and before the year the employee attains age 70 (72 before 1984).	On January 1 of the year after the credits are earned.
Year the employee attains age 70 (72 before 1984).	In the month age 70 (or 72) is attained.

§ 225.36 Effect of DRC's on survivor annuities.

(a) *Widow(er), remarried widow(er) or surviving divorced spouse.* Delayed retirement credits that the employee earned are used in computing the tier I component of a widow(er), remarried widow(er) or surviving divorced spouse annuity. All DRC's, including credits earned in the year of death, can be used in computing the widow(er) or surviving divorced spouse annuity beginning with the month of death. Delayed retirement credits for months up to, but not including, the month of death are used.

(b) *Other survivor annuities.* Delayed retirement credits cannot be used in computing any other survivor annuity based on the deceased employee's record.

Subpart E—Cost-of-Living Increases

§ 225.40 General.

A cost-of-living increase is an automatic increase in a PIA provided under section 215(i) of the Social Security Act. The Social Security Administration determines the percentage amount of any cost-of-living increase paid by the Board.

§ 225.41 How a cost-of-living increase is determined and applied.

Depending on the condition of the social security trust funds, the increase can be based on rises in either the consumer price index as published by the Department of Labor or the average wage index which is the average of the annual total wages used for computing a PIA. The increase is payable when the appropriate index for the third calendar quarter of one year shows an increase of at least three percent over the same index for the third calendar quarter of the previous year (or the last calendar quarter within which a legislated general benefit increase became effective). No increase is payable for the calendar year that immediately follows a year in which a legislated general benefit increase was effective. The increase amount is determined by multiplying the PIA by the percentage increase in the appropriate quarter of a previous year.

§ 225.42 Notice of the percentage amount of a cost-of-living increase.

The percentage amount of the cost-of-living increase is published in the FEDERAL REGISTER by the Secretary of Health and Human Services within 45 days of the end of the measuring period used in finding the increase.

§ 225.43 PIA's subject to cost-of-living increases.

The Retirement Tier I, Overall Minimum, Survivor Tier I, Employee RIB and RLS PIA's are adjusted for cost-of-living increases. The remaining PIA's described in subparts B and C of this part are frozen at the amounts determined under the Social Security Act as in effect on December 31, 1974.

§ 225.44 When a cost-of-living increase is payable.

A cost-of-living increase is payable beginning with December of the year for which the increase is due. The increase is paid in the January payment.

Subpart F—Recomputing PIA's

§ 225.50 General.

After an annuitant begins receiving an annuity, the PIA's may be recomputed as explained in § 225.52. Most recomputations result in an increase in the PIA. The Board pays a recomputed PIA when an increase of at least $1 results. Most recomputations are processed automatically and require no action by the annuitant.

§ 225.51 PIA's that are subject to recomputation.

The following PIA's are subject to recomputation—

(a) Tier I PIA;

(b) Survivor Tier I PIA;

(c) Overall Minimum PIA;

(d) Employee RIB PIA; and

(e) Residual Lump-Sum PIA.

§ 225.52 Reasons for recomputing a PIA.

There are three major reasons for recomputing a PIA:

(a) Recomputation to consider additional earnings.

(b) Recomputation when an employee is eligible for periodic pension payments based on other than railroad or social security earnings.

(c) Recomputation to use a new or different PIA formula, as provided in section 215(f) of the Social Security Act.

§ 225.53 Recomputation to consider additional earnings.

(a) *Additional earnings that cause a recomputation*—(1) *Earnings not included in earlier computation or recomputation.* The most common reason for recomputing a PIA is to include earnings that were not used previously, as described in paragraphs (a)(2) through (a)(4) of this section. The inclusion of these earnings may result in a revised Average Monthly Earnings or revised Average Indexed Monthly Earnings amount and, consequently, cause recomputation of the PIA.

(2) *Earnings in the year an employee becomes entitled to an age annuity or becomes disabled.* Earnings in the year an employee becomes entitled to an age annuity or becomes disabled are not used in the initial computation of the PIA. However, the Board does consider those earnings in a recomputation of the PIA and begins paying the higher benefits at the time described in paragraph (b) of this section.

(3) *Earnings not reported in time to use them in the computation of the PIA.* Because of the way reports of earnings are made, the earnings an employee has in the year before he or she becomes entitled to an annuity, becomes disabled, or dies, might not be reported in time to use them in computing the PIA. The Board recomputes the PIA with the new earnings information and begins paying annuitants the higher benefits based on the additional earnings at the time described in paragraph (b) of this section.

(4) *Earnings after entitlement that are used in a recomputation.* Earnings for a year after an employee becomes entitled to an annuity are used in a recomputation of a PIA when the earnings are higher than those for a year used in the previous PIA computation.

(b) *Effective date of recomputation to consider additional earnings.* A PIA that is recomputed to include additional earnings becomes payable at the latest of the following times:

(1) Date the annuity begins.

(2) January of the year following the year an employee receiving an age annuity attains age 62.

(3) January of the year following the year an employee becomes disabled.

(4) January of the year following the year in which the earnings are earned.

Example: Mr. Jones, a railroad employee, becomes entitled to an age annuity in June 1986, at the age of 62. Although Mr. Jones has earnings of $23,000 in the first five months of 1986, those earnings cannot be used in the initial computation of the Tier I PIA. However, effective with January 1, 1987, the Tier I PIA is recomputed to include the earnings for 1986.

§ 225.54 Recomputation when an employee is eligible for periodic pension payments based on other than railroad or social security earnings.

(a) *Description.* This recomputation serves as a reduction in the PIA for entitlement to a periodic pension based, in part or in whole, on earnings after 1956 not covered under either the Social Security Act or the Railroad Retirement Act. A recomputation for a periodic pension is made in accordance with sections 215(a)(7) and 215(f)(9) of the Social Security Act. A recomputation affecting the Retirement Tier I, Overall Minimum, or Residual Lump-Sum PIA is required when all the following conditions exist—

(1) The employee has less than 30 years of coverage as defined in section 215(a) of the Social Security Act. The years of coverage include railroad and social security earnings;

(2) The employee becomes eligible for an annuity after 1985; and

(3) The employee becomes eligible for the periodic pension payments after 1985 based, in part or in whole, on earnings after 1956 not covered under either the Social Security Act or the Railroad Retirement Act.

(b) *Effective date of recomputation.* The Retirement Tier I, Overall Minimum or Residual Lump-Sum PIA is recomputed when the employee becomes eligible for a periodic pension payment based on other than railroad or social security earnings. However, payment of the recomputed PIA is effective with the month in which the employee becomes entitled to the periodic pension.

§ 225.55 Recomputation to use a new or different PIA formula.

(a) *Description*—(1) *New computation formula.* If a new formula for computing or recomputing PIA's is enacted into law and the annuitant is eligible for the recomputation, the Board will recompute the PIA under the new formula.

(2) *Recomputation under different formula.* In some cases, a PIA may be recomputed under a computation formula different from the formula used in the computation (or earlier recomputation) of the PIA. The annuitant must be eligible for a computation or recomputation under the different formula.

(b) *Effective date of recomputation*—(1) *New computation formula.* A PIA recomputed under a newly enacted formula is effective with the month as directed in the legislation that establishes the new formula. The new PIA formula applies when it produces a PIA that is higher than the amount on which the existing annuity is based.

(2) *Different computation formula.* A PIA recomputed under a different formula is effective with the first month that the different formula produces a PIA that is higher than the PIA on which the existing annuity is based.

§ 225.56 Automatic recomputation.

Periodically, the Board reviews the earnings record of every retired, disabled and recently deceased employee to see if a recomputation of the PIA is necessary. When a recomputation is called for due to a change in the reported railroad or social security earnings, the Board processes it automatically. Increased benefits resulting from a recomputation are paid from the earliest month that the recomputation is effective. The annuitant does not have to request a recomputation to consider additional earnings, although the annuitant may request a recomputation before the automatic recomputation is processed. However, the effective date of the recomputation is the same, whether the recomputation is done automatically or at the request of the annuitant.

§ 225.57 Requesting a recomputation.

An annuitant who meets the conditions for a recomputation may request that his or her PIA be recomputed sooner than it would be recomputed automatically. Providing inclusion of the additional earnings increases the PIA, the Board will recompute the PIA from the earliest permissible date as described in this part.

§ 225.58 Waiver of recomputation.

If the employee or the employee's family are disadvantaged in any way by a recomputation of a PIA to consider additional earnings, a request can be made to waive or give up the right to the recomputation. Such a request must be in writing and be made by every entitled family member. A request for waiver of a recomputation applies only to that recomputation for which the request is made.

Subpart G—Adjusting PIA's

§ 225.60 Adjustment at age 62 when employee is entitled to an annuity based on 30 years of railroad service.

(a) *Description.* The Tier I PIA of an employee who is entitled to an age annuity based on 30 years of railroad service is adjusted when the employee reaches age 62. The Average Indexed Monthly Earnings on which the PIA is based is adjusted by using the year in which the employee attains age 62 as the eligibility year. This adjustment applies to any employee who attained age 60 or acquired 30 years of railroad service after June 30, 1984. The adjustment affects the tier I of the employee and spouse annuity.

(b) *Effective date of adjustment.* A PIA adjustment based on the employee's attainment of age 62 is effective with the first full month in which the employee is age 62. For purposes of a spouse age annuity tier I, the adjusted PIA is used beginning with the first full month both the employee and spouse are age 62.

PART 226—COMPUTING EMPLOYEE, SPOUSE, AND DIVORCED SPOUSE ANNUITIES

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AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 60 FR 22262, May 5, 1995, unless otherwise noted.

Subpart A—General

§ 226.1 Introduction.

This part explains how employee, spouse, and divorced spouse annuities are computed. It describes how to determine the years of railroad service and average monthly compensation used in computing the employee annuity rate. The railroad retirement family maximum, cost-of-living increases, and the recomputation of an annuity to include additional railroad earnings are also explained in this part.

§ 226.2 Definitions.

Except as otherwise expressly noted, as used in this part—

Annuity means a payment due an entitled individual for a calendar month and payable to him or her on the first day of the following month.

Eligible means that an individual meets all the requirements for payment of an annuity but has not yet applied for one.

Employee means an individual who is or has been in the service of an employer as defined in part 202 of this chapter.

Entitled means that an individual has applied for and has established his or her rights to benefits.

Railroad Retirement Act means the Railroad Retirement Act of 1974, as amended.

Retirement age means, with respect to an employee, spouse or divorced spouse who attains age 62 before January 1, 2000, age 65. For an employee, spouse or divorced spouse who attains age 62 after December 31, 1999, retirement age means the age provided for in section 216(l) of the Social Security Act.

Social Security Act means the Social Security Act as amended.

§ 226.3 Other regulations related to this part.

This part is closely related to part 216 of this chapter, which describes when an employee, spouse, or divorced spouse is eligible for an annuity, part 225 of this chapter, which explains the primary insurance amounts (PIA's) used in computing the employee, spouse and divorced spouse annuity rates, and part 229 of this chapter, which describes when and how employee and spouse annuities can be increased under the social security overall minimum. The creditable service and compensation used in determining the years of service and average monthly compensation are explained in parts 210 and 211 of this chapter. The beginning and ending dates of annuities are explained in part 218 of this chapter.

Subpart B—Computing an Employee Annuity

§ 226.10 Employee tier I.

Tier I of an employee annuity is an amount similar to the social security benefit the employee would receive based on combined railroad and social security earnings. The tier I benefit is computed as follows:

(a) A tier I PIA is computed based on combined railroad and social security earnings, as shown in §225.11 of this chapter. This PIA is adjusted for any delayed retirement credits or cost-of-living increases, as shown in subparts D and E of part 225 of this chapter, and is reduced for receipt of a pension

based upon non-covered service in accordance with section 215(a)(7) of the Social Security Act. The tier I of a disability annuity may also be adjusted for other benefits based on disability, as shown in §§ 226.70–226.74 of this part. Except in the case of an employee who retires at age 60 with 30 years of service, if the result is not a multiple of $1, it is rounded to the next lower multiple of $1. In the case of an employee who retires with an age reduced annuity based upon 30 years of service (see § 216.31 of this chapter) the tier I is not rounded until all reductions have been made.

(b) If the employee is entitled to a reduced age annuity (see § 216.31 of this chapter), the rate from paragraph (a) of this section is multiplied by a fraction for each month the employee is under retirement age on the annuity beginning date. The result is subtracted from the rate in paragraph (a) of this section. At present the fraction is 5/9 of 1% (or 1/180). If the employee retires before age 62 with at least 30 years of service, the employee is deemed age 62 for age reduction purposes and a 20% reduction is applied. This reduction remains in effect until the first full month throughout which the employee is age 62, at which time the tier I is recomputed to reflect interim increases in the national wage levels and the age reduction factor is recomputed, if necessary, in accordance with this paragraph.

(c) The amount from paragraph (a) or (b) of this section is reduced by the amount of any monthly benefit payable to the employee under title II of the Social Security Act, including any social security benefit payable under a totalization agreement between the Social Security Administration and another country. The social security benefit used to reduce the tier I may be an age or disability benefit on the employee's own earnings record, a benefit based on the earnings record of another person, or the total of two types of benefits. The amount of the social security benefit used to reduce tier I is before any deduction for excess earnings. It is after any reduction for other benefits based on disability. The result cannot be less than zero.

(d) The tier I is subject to automatic annual increases as provided for in subpart E of part 225 of this chapter.

Example: An employee born on November 3, 1919, becomes entitled to an age annuity effective October 1, 1982. Retirement age for individuals born in 1919 is age 65. He has less than 30 years of service. His tier I PIA Is $712.60, which is rounded down to $712. Since the employee is 25 months under age 65 when his annuity begins, $712 is multiplied by 25/180 (1/180 for each month under age 65), to produce an age reduction of $98.89, and a tier I rate after age reduction of $613.11. The employee is also entitled to a social security benefit of $190 a month. The employee's final tier I rate is $423.11.

§ 226.11 Employee tier II.

The tier II of an employee annuity is based only on railroad service. For annuities awarded after September 1981, the tier II benefit is computed as follows:

(a) The product obtained by multiplying the employee's creditable years of service by the average monthly compensation, determined as shown in subpart E of this part, is multiplied by seven-tenths of 1 percent (.007).

(b) If the employee is entitled to a vested dual benefit (see § 226.12 of this part), the result from paragraph (a) of this section is reduced by 25 percent of the vested dual benefit amount. This reduction is made before reduction of the tier II benefit for age. The result cannot be less than zero.

(c) If the railroad retirement family maximum applies, as shown in §§ 226.50–226.52 of this part, the amount from paragraph (a) or (b) of this section is reduced by the smaller of—

(1) The difference between the total railroad retirement maximum reduction amount and the reductions in the spouse and supplemental annuities; or

(2) The total tier II amount from paragraph (a) or (b) of this section.

(d) If the employee is entitled to a reduced age annuity (see § 216.31 of this chapter), the rate from paragraph (a) through (c) of this section is reduced in the same manner as the tier I as provided for in § 226.10 of this part. In the case of an employee with 30 years of service who is entitled to a reduced age annuity (see § 216.31 of this chapter), the age reduction only applies to the

tier I component; no age reduction applies to the tier II component.

(e) The total tier II amount (paragraphs (a) through (d) of this section), is increased by 32.5 percent of the percentage increase in the cost-of-living increase to the tier I annuity component. Each cost-of-living increase is paid only to an employee whose annuity begins on or before the effective date of the increase. The increases are effective on the same date as any cost-of-living increase to the tier I annuity component.

§ 226.12 Employee vested dual benefit.

(a) *General.* An employee vested dual benefit is payable, in addition to tiers I and II, to an employee who meets one of the following requirements:

(1) *Employee worked in the railroad industry in 1974.* An employee who worked for a railroad in 1974 and retired after 1974 is considered vested if on December 31, 1974, he or she had both 10 years of railroad service and sufficient quarters of coverage under the Social Security Act to qualify for a social security benefit. An employee qualified on this basis is eligible for vested dual benefit amounts computed on his or her railroad and social security credits through December 31, 1974.

(2) *Employee who did not work for a railroad in 1974.* An employee who did not work in the railroad industry in 1974, but who had 25 or more years of railroad service before 1975 or a current connection with the railroad industry on December 31, 1974, as defined in part 216 of this chapter, or a current connection when he or she retired, is also considered vested under the same conditions as an employee who had worked in the railroad industry in 1974.

(3) *An employee who completed 10 years or more years of railroad service (but less than 25) before 1975 but left the industry before 1975 and did not have a current connection on December 31, 1974 or when he or she retired.* Such an employee is considered vested only if he or she had sufficient social security quarters of coverage to qualify for a social security retirement benefit as of the end of the year prior to 1975 in which he or she left the railroad industry. The vested dual benefit amount is based only on credits acquired through the last year of pre-1975 railroad service instead of through December 31, 1974.

(b) *Computation.* The employee vested dual benefit is computed as follows:

(1) The combined earnings dual benefit PIA is subtracted from the total of the railroad earnings dual benefit PIA and the social security earnings dual benefit PIA (see part 225 of this chapter for an explanation of these PIA's).

(2) The result from paragraph (b)(l) of this section is adjusted for any applicable cost-of-living increase, as shown in § 226.13 of this part.

(3) If the employee is entitled to a reduced age annuity (see § 216.1 of this chapter), the rate from paragraph (b)(2) of this section is reduced in the same manner as the tier I as provided for in § 226.10 of this part. In the case of an employee with 30 years of service who is entitled to an annuity reduced for age, the age reduction applies only to the tier I component; no age reduction applies to the vested dual benefit.

(4) The vested dual benefit payable in a given year may also be reduced for insufficient funding as shown in part 233 of this chapter.

Example: An employee born on November 3, 1919, becomes entitled to an annuity including a vested dual benefit on October 1, 1982. His combined earnings dual benefit PIA is $254.90, his railroad earnings dual benefit PIA is $93.80, and his social security earnings dual benefit PIA is $244.70. The vested dual benefit before cost-of-living increase is $83.60 ($93.80 + $244.70 −$254.90 = $83.60). A cost-of-living increase of $67.72 (81 percent of $83.60. See § 226.13 of this part) results in a vested dual benefit of $151.32. Retirement age for a person born in 1919 is age 65. Since the employee is 25 months under age 65 when the annuity begins, $151.32 is multiplied by 25/180, to produce an age reduction of $21.02 and a vested dual benefit rate after age reduction of $130.30.

§ 226.13 Cost-of-living increase in employee vested dual benefit.

If the employee's annuity begins June 1, 1975 or later, a cost-of-living increase is added to the total vested dual benefit amount. This increase is based on the cost-of-living increases in social security benefits during the period from January 1, 1975, to the earlier of the date the employee's annuity begins or January 1, 1982. The increases are effective on June 1 of each year through

1981. The percentage increase for annuities that begin June 1, 1981, or later is 81 percent.

§ 226.14 Employee regular annuity rate.

The regular annuity rate payable to the employee is the total of the employee tier I, tier II, and vested dual benefit amounts, from §§ 226.10–226.12.

§ 226.15 Deductions from employee regular annuity rate.

The employee annuity as computed under this subpart may be reduced by premiums required for supplemental medicare coverage, income tax withholding, recovery of debts due the Federal government, garnishment pursuant to part 350 of the chapter and property awards as provided for in part 295 of this chapter.

§ 226.16 Supplemental annuity.

A supplemental annuity is payable in addition to tiers I and II and the vested dual benefit to an employee who meets the requirements of § 216.41 of this chapter. The supplemental annuity is equal to $23 plus $4 for each full year of service, over 25 years of service, up to a maximum of $43. The supplemental annuity may be reduced by the railroad retirement family maximum as shown in §§ 226.50–226.52 of this part, or for the receipt of a private pension benefit as explained in part 227 of this chapter.

Subpart C—Computing a Spouse or Divorced Spouse Annuity

§ 226.30 Spouse or divorced spouse tier I.

(a) *General.* The tier I of a spouse or divorced spouse annuity is an amount similar to the social security benefit the spouse or divorced spouse would receive based on the employee's combined railroad and social security earnings. In the case of an employee who retires before age 62 with 30 years of service, the spouse tier I is simply 50% of the employee tier I until the first month throughout which both the employee and spouse are age 62 at which time the tier I is an amount similar to the social security benefit on the employee's combined railroad and social security earnings.

(b) *Reduction for other disability benefits.* The spouse or divorced spouse tier I may be adjusted for other disability benefits received by a disabled employee, as shown in §§ 226.70–226.74 of this part.

(c) *Reduction for government pension.* The amount in paragraphs (a) or (b) of this section is reduced (but not below zero) by the amount of any government pension payable on the spouse's or divorced spouse's earnings record, as described in § 226.31 of this part.

(d) *Rounding.* The last tier I rate from paragraph (a), (b) or (c) of this section, if not a multiple of $1, is rounded to the next lower multiple of $1. However, in cases in which the spouse is in receipt of an age reduced 60/30 annuity or in which the employee with 30 years of service began a disability annuity July 1, 1984, or later, the spouse tier I is not rounded until all reductions have been made. See § 226.10(a).

(e) *Age reduction.* If the spouse or divorced spouse is entitled to a reduced age annuity (see §§ 216.51 and 216.52 of this chapter), the rounded tier I rate from paragraph (d) of this section is multiplied by a fraction for each month the spouse or divorced spouse is under retirement age on the date the annuity begins. The result is subtracted from the rate from paragraph (d) of this section. At present the fraction is 25/36 of 1% (or 1/144). In the case of an employee with 30 years of service who is awarded a disability annuity on July 1, 1984, or later, where the spouse does not have a child of the employee under age 18 in care, the spouse tier I is reduced for each month the spouse is under retirement age on the date the spouse annuity begins. If the spouse is age 60 or 61, he or she is deemed to be age 62 for purposes of the age reduction. The age reduction is applied before reduction for a government pension.

(f) *Reduction for social security benefit.* The previous tier I rate, from paragraph (d) or (e) of this section, is reduced by the amount of any monthly benefit payable to the spouse or divorced spouse under title II of the Social Security Act. The social security benefit used to reduce tier I may be an age or disability benefit on the spouse's

or divorced spouse's own earnings record, a benefit based on the earnings record of another person, or the total of two types of benefits. The result cannot be less than zero.

(g) *Reduction for employee annuity.* If the spouse or divorced spouse is entitled to an employee annuity on his or her own wage record, the spouse or divorced spouse tier I is reduced for the spouse's own employee annuity as follows:

(1) *Spouse.* If either the employee or the spouse had some railroad service before 1975, the previous tier I rate from paragraphs (d) through (f) of this section, whichever applies, is reduced (but not below zero) by the spouse's own employee tier I rate, as computed under § 226.10 of this part. If both the employee and spouse began railroad service after 1974, the spouse's total annuity rate, as shown in § 226.33, is reduced (but not below zero) by the spouse's own employee total annuity rate, as shown in § 226.14. These reductions are effective from the later of the date the employee or spouse annuity begins.

(2) *Divorced spouse.* The previous tier I rate from paragraphs (d) through (f) of this section, whichever applies, is reduced (but not below zero) by the divorced spouse's own employee total annuity rate as shown in § 226.14.

Example: The computation of the spouse tier I may be illustrated as follows: A railroad employee's wife who was born on September 16, 1920, becomes entitled to a spouse annuity on October 1, 1982. She is also entitled to a social security benefit of $190 a month effective October 1, 1982. Her husband's employee tier I PIA is $712.60. The spouse tier I is $356.30 (50 percent of $712.60). This is rounded down to $356. Since she is 35 months under age 65, the present retirement age when the annuity begins, $356 is multiplied by 35/144, to produce an age reduction of $86.53 and a tier I rate after age reduction of $269.47. Her final tier I rate effective October 1, 1982, after reduction for social security benefits, is $79.47 ($269.47 − $190.00).

§ 226.31 Reduction for public pension.

(a) The tier I annuity component of a spouse/divorced spouse annuity, as described in the preceding sections of this part, is reduced if the spouse/divorced spouse is in receipt of a public pension.

(b) *When reduction is required.* Unless the spouse or divorced spouse annuity meets one of the exceptions in paragraph (d) of this section, the tier I annuity component is reduced each month the annuitant is receiving a monthly pension from a Federal, state, or local government agency (government pension), but excluding a pension paid by a government of a foreign country, for which he or she was employed in work not covered by social security on the last day of such employment. For purposes of this section, Federal government employees are not considered to be covered by social security if they are covered for Medicare but are not otherwise covered by social security.

(c) *Payment in a lump sum.* If the government pension is not paid monthly or is paid in a lump-sum payment, the Board will determine how much the pension would be if it were paid monthly and then reduce the monthly railroad retirement annuity accordingly. The number of years covered by a lump-sum payment and thus the period when the annuity will be reduced, will generally be clear from the pension plan. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period or the equivalent monthly pension benefit is not clear, it may be necessary for the Board to determine the reduction period on an individual basis.

(d) *Exceptions.* The reduction does not apply:

(1) If the annuitant is receiving a government pension based on employment for an interstate instrumentality; or

(2) If the annuitant receives or is eligible to receive a government pension for one or more months in the period December 1977 through November 1982 and he or she meets the requirements for social security benefits that were applied in January 1977 (even though he or she did not actually claim such benefits nor become entitled to such benefits until a later month). The January 1977 requirements are, for a man, a one-half support test (see paragraph (e) of this section), and, for a woman

claiming benefits as a divorced spouse, marriage for at least 20 years to the insured worker. A person is considered eligible for a government pension for any month in which he or she meets all the requirements for payment except that he or she is working or has not applied; or

(3) If the annuitant was receiving or eligible (as defined in paragraph (d)(2) of this section) to receive a government pension for one or more months before July 1983, and he or she meets the one-half support test (see paragraph (e) of this section). If the annuitant meets the exception in this paragraph but he or she does not meet the exception in paragraph (d)(2) of this section, December 1982 is the earliest month for which the reduction will not affect his benefits; or

(4) If the annuitant has been eligible for a government pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, the Board will consider the annuitant to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (d)(2) and (d)(3) of this section. If the annuitant meets an exception solely because of this paragraph, his or her benefits will be unreduced for months after November 1984 only.

(e) *The one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (d)(2) of this section and for a man or a woman to meet the exception in paragraph (d)(3) of this section, he or she must meet a one-half support test. One-half support is defined in part 222 of this chapter. One-half support must be met at one of the following times:

(1) If the employee upon whose compensation the spouse or divorced spouse annuity is based had a period of disability, as defined in part 220 of this chapter, which did not end before he or she became entitled to an age and service or disability annuity, the spouse/divorced spouse annuitant must have been receiving at least one-half support from the employee either—

(i) At the beginning of the employee's period of disability; or

(ii) At the time the employee became entitled to an age and service or disability annuity.

(2) If the employee upon whose compensation the spouse or divorced spouse annuity is based did not have a period of disability, as defined in part 220 of this chapter, at the time of his or her entitlement, the spouse or divorced spouse annuitant must have been receiving at least one-half support from the employee at the time the employee became entitled to an age and service or disability annuity.

(f) *Amount of reduction.* (1) If the spouse/divorced spouse annuitant becomes eligible for a government pension after June 1983, the Board will reduce (to zero, if necessary) the tier I annuity component by two-thirds of the amount of the monthly pension. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(2) If the spouse/divorced spouse annuitant became eligible for a government pension before July 1983 and he or she did not meet one of the exceptions in paragraph (d) of this section, the Board will reduce (to zero, if necessary) the tier I component by the full amount of the pension for months before December 1984 and by two-thirds the amount of his or her monthly pension for months after November 1984. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(g) *Reduction not applicable.* This reduction is not applied to claimants who both filed and were entitled to a spouse benefit prior to December 1977.

§ 226.32 Spouse tier II.

The spouse tier II benefit is computed as follows:

(a) The employee's tier II amount as computed under § 226.11 of this part, after any reduction for entitlement to a vested dual benefit but before reduction for the railroad retirement family maximum, is multiplied by 45 percent. The spouse tier II is recomputed if the employee's tier II rate is reduced for entitlement to a vested dual benefit after the beginning date of the spouse annuity.

(b) If tier I of a spouse annuity is reduced for the spouse's employee annuity, as provided for in § 226.30(g) of this part, the reduction is restored in tier II. The restored amount is payable on the effective date of the spouse or the employee tier I benefit, whichever is later. The previous tier II rate is increased by the restored amount, which is determined as follows:

(1) *Initial restored amount.* The restored amount is the amount by which the spouse tier I was reduced by reason of receipt of an employee annuity on the date the restored amount is first payable. The restored amount is only payable if either the employee or spouse had railroad service prior to 1975.

(2) *Recomputation of restored amount.* The restored amount is recomputed if the spouse becomes entitled to a government pension, a social security benefit, or a different type of social security benefit after the date the initial restored amount is effective. The recomputed amount is the amount by which the spouse tier I is reduced by reason of receipt of an employee annuity on the effective date of the entitlement to a government pension or social security benefit.

(3) *Cost-of-living increase in restored amount.* If an initial or recomputed restored amount is effective before the effective date of the cost-of-living increase shown in paragraph (e) of this section, the restored amount is multiplied by the percentage increase that applies. The result is added to the restored amount on the effective date of the increase for each year that the increase is payable.

(c) If the employee's tier II has been reduced pursuant to section 3(g)(2) of the Railroad Retirement Act (takeback provision) the spouse tier II is reduced by one half of the ''takeback'' in the employee tier II.

(d) If the railroad retirement family maximum applies, as shown in §§ 226.50–226.52 of this part, the spouse tier II rate, as determined in paragraphs (a) through (c) of this section, is reduced by the smaller of—

(1) The total railroad retirement maximum reduction amount; or

(2) The previous spouse tier II rate.

(e) The tier II rate, from paragraphs (a) through (d) of this section, is increased by the same percentage as the employee tier II increase described in § 226.11(e) of this part.

(f) If the spouse is entitled to a reduced age annuity (see § 216.51 of this chapter), the tier II rate, as determined in paragraphs (a) through (e) of this section is reduced in the same manner as the tier I as provided for in § 226.30(e) of this part.

Example: An employee's tier II rate is $329.63 effective October 17, 1981. The spouse rate is $148.33 (45 percent × $329.63) effective October 17, 1981. This is increased to $151.89 effective June 1, 1982, by a cost-of-living increase of 2.4 percent. The spouse is 35 months under age 65, the present retirement age, when the annuity begins. The $151.89 rate is multiplied by 35/144 to produce an age reduction of $36.92. This is subtracted from $151.89 to produce a final rate of $114.97.

§ 226.33 Spouse regular annuity rate.

The final tier I and tier II rates, from §§ 226.30 and 226.32, are added together to obtain the total spouse regular annuity rate.

§ 226.34 Divorced spouse regular annuity rate.

The regular annuity rate of a divorced spouse is equal to his or her tier I amount. The divorced spouse is not entitled to a tier II benefit.

§ 226.35 Deductions from regular annuity rate.

The regular annuity rate of the spouse and divorced spouse annuity may be reduced by premiums required for supplemental medicare coverage, income tax withholding (spouse annuity only), recovery of debts due the Federal government, and garnishment pursuant to part 350 of this chapter.

Subpart D—Railroad Retirement Family Maximum

§ 226.50 General.

There is a monthly ceiling on total family benefits which limits the amount of certain portions of the employee and spouse annuity. This railroad retirement family maximum amount varies according to the employee's earnings in the ten-year period

that ends with the year in which his or her annuity begins. If the employee and spouse annuity amounts described in § 226.52 of this part are higher than the maximum from § 226.51 of this part, first the spouse tier II, then the supplemental annuity and, finally, the employee tier II are reduced until the total annuity amount is equal to the maximum or until the spouse tier II and the employee supplemental annuity and tier II have been reduced to zero, whichever comes first. The reduction for the railroad retirement family maximum is first computed from the date the employee's annuity begins. It is recomputed if the employee's tier II rate is reduced for entitlement to a vested dual benefit. It is also recomputed if a workers' compensation or other disability benefit begins or ends, or the employee's tier I benefit or supplemental annuity begins after the beginning date of the regular employee annuity. Finally, it is recomputed if a spouse who was entitled to an annuity divorces the employee or the spouse annuity entitlement ends.

§ 226.51 Maximum monthly amount.

The railroad retirement family maximum is equal to an employee's ''final average monthly compensation'' (FAMC) up to ½ of 1/12 of the annual maximum tier I earnings as shown in part 224 of this chapter in the year the annuity begins plus 80 percent of so much of his or her FAMC as exceeds ½ of 1/12 of the tier I maximum in the year the annuity begins. For this purpose, the FAMC is determined by dividing the individual's total earnings up to the tier II earnings limit as shown in part 211 of this chapter for the two highest-earnings years out of the last 10 calendar years, including the year of retirement, by 24. The railroad retirement maximum cannot be more than the FAMC and cannot be less than $1,200.

Example: An employee's annuity begins on December 2, 1982. He has yearly earnings that exceed the tier II annual maximum of $24,300 in 1982 and $22,200 in 1981. The FAMC is the sum of the tier II maximum for 1981 and 1982 divided by 24 ($24,300 + $22,200÷24) or $1,937.50. The maximum which may be credited to a month for tier I in 1982 is $2,700. The family maximum is $1,350 (½ of 1/12 of the annual tier I maximum) plus $470 (80% of the difference between $1,937.50 and $1,350) or $1,820.

§ 226.52 Total annuity subject to maximum.

The total annuity amount which is compared to the maximum monthly amount to determine if a reduction for the railroad retirement family maximum applies is determined by adding together the amounts in paragraphs (a) and (b) of this section. A hypothetical spouse annuity amount is included from the beginning date of the employee annuity if the spouse is not entitled to an annuity at the time the maximum calculation is made.

(a) *Employee annuity amounts.* The following amounts are added together—

(1) The employee tier I amount, effective on the date the employee's tier I benefit begins or, if later, on the date a reduction for other disability benefits begins or ends, as shown in § 226.71 of this part. This amount is before any reduction for age or social security benefits but after including any delayed retirement credits, after any reduction for other disability benefits, and after rounding; and

(2) The employee tier II rate before reduction for the railroad retirement family maximum, effective on the employee's annuity beginning date and, if later, on the date the tier II is first reduced for a vested dual benefit, as shown in § 226.11 of this part; and

(3) The initial supplemental annuity rate effective on the date the supplemental annuity begins, before any reduction for a private pension, as shown in part 227 of this chapter.

(b) *Spouse annuity amounts.* The following amounts are added together—

(1) The spouse tier I amount, which is or would be effective on the date the employee's annuity or tier I benefit begins, as shown in § 226.30. This amount is before any reduction for other disability benefits, age, or social security benefits, but after any reduction for a government pension or employee annuity; and

(2) The spouse tier II rate which is or would be effective on the employee's annuity beginning date, the date the employee's tier I benefit begins, or the

date the employee's tier II rate is reduced for a vested dual benefit, as shown in § 226.11. This rate includes the restored amount but does not include any cost-of-living increase in the tier II original rate or restored amount. It is the rate before reduction for the railroad retirement family maximum or age minus any cost-of-living increases.

Subpart E—Years of Service and Average Monthly Compensation

§ 226.60 General.

The years of service and average monthly compensation used in computing an employee's tier II annuity rate are based on the employee's creditable railroad service and compensation as described in parts 210 and 211 of this chapter. In computing the average monthly compensation, the compensation for each year cannot be higher than twelve times the tier II monthly maximum creditable for that year, as described in part 211 of this chapter.

§ 226.61 Use of military service.

(a) *Claim for use of military service.* An employee is deemed to have filed a claim for the use of military service and earnings as service and compensation under the Railroad Retirement Act if—

(1) The employee indicates on the annuity application or another signed statement that he or she has military service;

(2) The employee does not specifically request that the military service be credited as wages under the Social Security Act;

(3) The military service is creditable under the Railroad Retirement Act, as shown in part 212 of this chapter; and

(4) Using the military service as railroad service and compensation would be to the employee's advantage (the employee and his or her family would receive higher total benefits than if the military service were credited under the Social Security Act).

(b) *Effective date for use of military service.* Military service can be used as service and compensation under the Railroad Retirement Act starting with the date the annuity begins but no earlier than twelve months before the employee files an application or statement showing that he or she has military service.

§ 226.62 Computing average monthly compensation.

The employee's average monthly compensation is computed by first determining the employee's highest 60 months of railroad compensation (disregarding compensation in excess of the maximum creditable tier II compensation for that year). The total of the highest 60 months is then divided by 60 to determine the average monthly compensation.

§ 226.63 Determining monthly compensation.

(a) *Based on yearly compensation.* If Board records do not show monthly compensation for a year, the monthly compensation is determined by dividing the total compensation reported for the year by the number of months of service credited to the employee for that year.

(b) *For employee with government employment and no railroad service for 60-month period before annuity begins*—(1) *General.* The compensation used in determining the average monthly compensation (AMC) is indexed for an employee who has not worked in the railroad industry for the 60-month period before the month the employee's annuity begins and whose major employment during that period was for a government agency listed in § 216.16 of this chapter. The compensation is indexed by multiplying it by the quotient obtained by dividing the average annual wage for the indexing year by the average annual wage for the year being indexed. If the month for which compensation is being indexed is before 1951, the average annual wage for 1951 is used.

(2) *Indexing year defined.* The indexing year is the second year before the year in which the annuity begins.

Subpart F—Reduction for Workers' Compensation and Disability Benefits Under a Federal, State, or Local Law or Plan

§ 226.70 General.

For any month an employee disability annuitant is entitled to workers' compensation or a public disability benefit, the tier I benefit of the spouse or divorced spouse is reduced due to receipt of such benefits. (If both spouse and divorced spouse annuities are payable, the reduction amount is divided and applied in equal amounts to both the spouse and divorced spouse tier I benefits.) The employee tier I is reduced by the difference between the total reduction amount, described in § 226.71 of this part, and the reduction in the spouse and divorced spouse tier I benefits.

§ 226.71 Initial reduction.

(a) *When reduction is effective.* A reduction for other disability benefits begins with the first month the employee is receiving both a disability annuity and workers' compensation or a public disability benefit. The reduction ends with the month before the month in which the employee becomes 65 years old or with the month in which the workers compensation or public disability benefit ends.

(b) *Amount of reduction.* The reduction for other disability benefits equals the difference between—

(1) The total tier I rates of the employee, spouse, and divorced spouse, before any reductions (age, public pension, social security benefits, etc.) plus the monthly amount of the workers' compensation of public disability benefit; and

(2) The higher of—

(i) Eighty percent of the employee's average current earnings, as defined in this section; or

(ii) The total tier I rates, as described in paragraph (b)(1) of this section.

Example 1: Harold is entitled to a monthly disability annuity with a tier I component of $507 and a monthly public disability benefit of $410 from the state. Eighty percent of Harold's average current earnings is $800. Because this amount is higher than Harold's tier I component, to determine the reduction for other disability benefits the Board subtracts this amount ($800) from the total of Harold's tier I component ($507) and public disability benefit ($410) which results in a reduction amount of $117 ($917–$800). This leaves Harold with a reduced tier I amount of $390 ($507–$117).

Example 2: Tom is entitled to a disability annuity with a tier I component of $560. His wife and divorced wife are both entitled to annuities with tier I components of $280 each. Total benefits are $1,120. Tom is receiving a monthly workers' compensation benefit of $500 from the state. Eighty percent of Tom's average current earnings is $820. Because the total benefit ($1,120) is higher than Tom's average current earnings, to determine the reduction for other disability benefits the Board subtracts this amount from $1,620 ($1,120 plus $500) which results in a reduction amount of $500. This means that the tier I of the spouse and divorced spouse annuity are each reduced by $250.

(c) *Average current earnings, defined.* An employee's ''average current earnings'' is the highest of—

(1) The average monthly wage (AMW) used to compute the tier I AMW PIA. (The earnings are not indexed, even if the tier I PIA which is being paid is based on average indexed monthly earnings. See part 225 of this chapter.); or

(2) One-sixtieth of the employee's total earnings covered under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum earnings used in computing social security benefits) for the five consecutive years after 1950 in which the employee had the highest earnings. The result, if not a multiple of $1, is rounded to the next lower multiple of $1; or

(3) One-twelfth of the employee's total earnings covered under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum earnings used in computing social security benefits) for the year of highest earnings in the period which includes the year in which the employee became disabled and the five preceding years. The result, if not a multiple of $1, is rounded to the next lower multiple of $1.

§ 226.72 Benefits that do not cause a reduction.

The tier I is not reduced for the following types of benefits:

(a) A benefit paid under a law or plan that provided, on February 18, 1981, for reducing the benefit for entitlement to a disability insurance benefit under the Social Security Act.

(b) A Federal disability benefit based on service for other than a state or local government, if all or part of that service is covered under the Social Security Act.

(c) A disability benefit paid by the Federal government or a state or local government based on state or local employment, if all or substantially all of that employment is covered under the Social Security Act. ''Substantially all'' means 85 percent or more of the employment.

(d) A benefit paid by the Veteran's Administration.

(e) Private disability benefits.

(f) Amounts paid under the Federal Employers' Liability Act (FELA).

(g) Benefits based on need, such as welfare benefits or supplemental security income.

§ 226.73 Changes in reduction amount.

The reduction amount is not changed when a tier I benefit increases because of a recomputation or a general adjustment in annuity rates, such as a cost-of-living increase. However, the reduction amount may change for the following reasons:

(a) *A spouse or divorced spouse becomes entitled to a tier I benefit after the effective date of the reduction.* The reduction amount is recomputed as if the spouse or divorced spouse were entitled to a tier I benefit on the date the reduction first applied. The new reduction amount applies beginning with the date the spouse or divorced spouse tier I benefit begins.

Example: An employee became entitled to an annuity with a tier I component of $500 on May 1, 1991. He was also receiving a state disability benefit of $300 a month based on employment not covered under the Social Security Act. On June 1, 1991, the employee's tier I increased to $520.70. On October 1, 1991, the employee's wife becomes entitled to an annuity with a tier I benefit of $260.00. The tier I amount ($250) that would have been payable to the wife on May 1, 1991 (assuming she had been eligible for a benefit at that time) is used to determine the reduction for other disability benefits beginning October 1, 1991.

(b) *The tier I benefit of a spouse or divorced spouse annuity ends after the effective date of the reduction.* The new reduction amount is computed using the tier I rate to which the employee was entitled when the reduction first applied. The new reduction amount applies beginning with the month after the month in which the spouse or divorced spouse tier I benefit ends.

(c) The average current earnings are redetermined, as shown in § 226.74.

(d) *The amount of the other disability benefit changes.* The reduction amount is recomputed to use the new benefit rate beginning with the date on which the new rate is payable. Any increases in the tier I amounts which were effective after the reduction first applied are not included in computing the new reduction amount.

Example: The employee's tier I benefit is $500 on May 1, 1991, when the annuity is first reduced for other disability benefits. The tier I increases to $520 effective June 1, 1991. When the amount of the disability benefit changes on October 1, 1991, $500, not $520, is used as the employee tier I amount in recomputing the reduction amount.

§ 226.74 Redetermination of reduction.

(a) *General.* The average current earnings are redetermined in the second year after the year the reduction for other disability benefits was first applied and every third year after that. The redetermined amount is used only if it results in a lower reduction amount. The new reduction amount is effective with January of the year after the redetermination is made.

(b) *Redetermined average current earnings.* The average current earnings are redetermined by multiplying the initial average current earnings amount by—

(1) The average of the total wages (including wages that exceed the maximum used in computing social security benefits) of all persons for whom wages were reported to the Secretary of the Treasury for the year before the year of redetermination, divided by the average of the total wages reported to the Secretary of the Treasury for 1977 or, if later, the year before the year for which the reduction was first computed. If the result is not a multiple of

$1, it is rounded to the next lower multiple of $1; or

(2) If the reduction was first computed before 1978, the average of all taxable wages reported to the Secretary of Health and Human Services for the first quarter of 1977, divided by the average of all taxable wages reported to the Secretary of Health and Human Services for the first quarter of the year before the year for which the reduction was first computed. If the result is not a multiple of $1, it is rounded to the next lower multiple of $1.

Subpart G—Recomputation To Include Additional Railroad Service and Compensation

§ 226.90 When recomputation applies.

An employee's annuity may be recomputed to include additional railroad service and compensation and social security wages which the employee earns after the beginning date of the employee annuity. The annuity is recomputed only if the recomputation increases the annuity rate by more than $1 a month or results in a lump-sum payment of more than $5. Before a recomputed rate can be paid, the employee must stop working in the railroad industry. A recomputed tier I component is payable beginning with January 1 of the year after the year in which the wages or compensation are earned or (provided the employee is age 62 or disabled), in the case of railroad compensation, in the year after the employee stops working in the railroad industry. A recomputed tier II component is payable from the date the annuity is reinstated after the employee has ceased railroad work.

§ 226.91 How an employee annuity rate is recomputed.

(a) *Tier I.* A recomputation is made if any social security wages or railroad compensation for a year in which the employee returned to work are higher than the earnings for a year included in the previous computation of the tier I PIA, as shown in part 225 of this chapter. The higher earnings are used instead of the lower earnings for the earlier year to determine the average monthly wage or average indexed monthly earnings. Part 225 of this chapter describes how a PIA is recomputed.

(b) *Tier II.* The additional service is added to the years of service previously used in computing the tier II rate. The additional compensation is used to recompute the average monthly compensation, if the compensation for a month in which the employee returned to railroad service is higher than the compensation for a month used in the previous computation of the average monthly compensation. The higher monthly compensation is used instead of the lower compensation for a previous month to determine the new average monthly compensation as shown in § 226.62 of this part. The increased years of service and average monthly compensation are used in computing a new tier II rate, as shown in § 226.11 of this part.

Example: An employee receiving an annuity which began on January 1, 1992, returns to railroad service for 10 months in 1992 and 2 months in 1993. He stops work on February 20, 1993. He has earnings of $34,500.00 in 1992 and $5,200.00 in 1993. His tier II rate effective January 1, 1992, was based on 26 years (312 months) of service and an average monthly compensation of $2,995 ($179,700÷60). The additional 12 months of service increases the year of service used in computing the tier II rate to 27 (312 months + 12 months = 324 months ÷ 12 = 27). The 1992 earnings of $34,500.00 are used instead of 1987 earnings of $32,700.00. The 1993 earnings are not used because they are lower than the earnings for previous months used in computing the average monthly compensation. The additional $1,800.00 in earnings increases the average monthly compensation to $3,025 ($179,100 + $1,800.00 = $181,500.00÷60). The initial tier II amount is increased from $545.09 (26×$2,995×.007) to $571.73 (27×$3,025×.007), effective with the date of annuity reinstatement, March 1, 1993.

§ 226.92 Effect of recomputation on spouse and divorced spouse annuity.

The annuity of a spouse or divorced spouse is recomputed to use the employee's recomputed tier I PIA and tier II rate, if the recomputation results in a lump-sum payment of more than $5 or an increase in the spouse or divorced spouse annuity rate of more than $1 a month. The spouse or divorced spouse annuity rate is recomputed beginning with the same date the employee's annuity rate is recomputed.

PART 227—COMPUTING SUPPLEMENTAL ANNUITIES

Sec.
227.1 Introduction.
227.2 Initial supplemental annuity rate.
227.3 Reduction for railroad retirement family maximum.
227.4 Reduction for employer pension.
227.5 Employer tax credits.

AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 50 FR 11502, Mar. 22, 1985, unless otherwise noted.

§ 227.1 Introduction.

This part explains how to compute a supplemental annuity. A supplemental annuity is payable to an employee who meets the requirements in § 216.12 of this chapter.

§ 227.2 Initial supplemental annuity rate.

The supplemental annuity rate, before reduction for the railroad retirement family maximum or any private pension, is $23 for an employee's first 25 years of service plus $4 for each added year of service up to 30 years. The highest supplemental annuity rate is $43 for an employee with 30 or more years of service.

§ 227.3 Reduction for railroad retirement family maximum.

If the railroad retirement family maximum applies, and the reduction amount is higher than the spouse tier II rate, as shown in part 226 of this chapter, the initial supplemental annuity rate from § 227.2 is reduced by the smaller of—

(a) The difference between the total railroad retirement maximum reduction amount and the reduction in the spouse annuity; or

(b) The total supplemental annuity rate from § 227.2.

[50 FR 11502, Mar. 22, 1985, as amended at 54 FR 12903, Mar. 29, 1989]

§ 227.4 Reduction for employer pension.

(a) *General.* The supplemental annuity for each month is reduced by the amount of any private pension the employee is receiving for that month based on the contributions of a railroad employer. This reduction is applied to the supplemental annuity amount after any reduction for railroad retirement family maximum. Private pension is explained in § 216.14 of this chapter.

(b) *Private pension reduced for supplemental annuity.* If the employer reduces the private pension for the employee's entitlement to the supplemental annuity, the reduced pension amount is subtracted from the supplemental annuity. However, the reduction in the supplemental annuity can be no greater than the difference between the supplemental annuity amount, after any reduction for railroad retirement family maximum, and the amount the private pension is reduced for the supplemental annuity. This guarantees that the sum of the reduced supplemental annuity and the reduced employer pension is not less than the amount of the full employer pension.

Example: The full employer pension is $80. This is reduced by $35 because of the employee's entitlement to a supplemental annuity. The initial supplemental annuity rate is $43.

Full employer pension	$80
Reduction for supplemental annuity	−35
Reduced pension amount	45
Supplemental annuity	43
Reduced pension amount	−45
	0
Guarantee amount:	
Supplemental annuity	43
Reduction in private pension	−35
	8
Supplemental annuity	43
Reduction in private pension	−8
Reduced supplemental annuity	35

The reduced supplemental annuity amount is $35. This amount plus the reduced employer pension of $45 equals $80, the full amount of the employer pension.

(c) *Part of private pension based on employee contributions.* If the employer pension is based on both employer and employee contributions, a special formula is used to determine the amount to be subtracted from the supplemental annuity. The Board first computes the pension amount the employee's contributions could have purchased from a private insurance company. That amount is subtracted from the total employer pension. The result is the pension amount used to reduce the supplemental annuity.

§ 227.5 Employer tax credits.

Employers are entitled to tax credits if they pay non-negotiated pensions to former employees whose supplemental annuities are reduced because of the pensions. Non-negotiated pensions are paid under pension plans that are not established by collective bargaining agreements. The tax credits for each month equal the sum of the reductions for employer pensions in the supplemental annuities of all former employees for that month. The Board sends a report of total tax credits to each employer after the end of each calendar quarter. The credits are applied to the man-hour supplemental annuity tax the employer pays the Internal Revenue Service under section 3221 of the Railroad Retirement Tax Act.

PART 228—COMPUTATION OF SURVIVOR ANNUITIES

Subpart A—General

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228.11 Computation of the tier I annuity component of a widow(er) with a child in care, remarried widow(er) with a child in care, or a surviving divorced spouse with a child in care.
228.12 Computation of the tier I annuity component of a child's insurance annuity.
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228.50 Tier II annuity component widow(er), child, or parent.
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228.60 Cost-of-living increase.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 60 FR 16368, Mar. 30, 1995, unless otherwise noted.

Subpart A—General

§ 228.1 Introduction.

(a) *What does this part include?* This part includes the computation of a widow(er)'s, disabled widow(er)'s, remarried widow(er)'s, surviving divorced spouse's, parent's, and child's insurance annuity under the Railroad Retirement Act. This part describes the two annuity components or tiers which are included in these annuities. The tier I annuity component, which may be payable in all of the above annuities, is described in subpart B of this part. Subpart C of this part describes the tier II annuity component which is only applicable to the widow(er)'s, disabled widow(er)'s, parent's, and child's annuity.

(b) *Other relevant parts.* (1) Part 225, Primary Insurance Amount Determinations, describes the various types of primary insurance amounts which form the basis of the computation of the tier I annuity component described in this part.

(2) Part 216, Eligibility for an Annuity, describes the eligibility requirements for receipt of the annuity computations described in this part.

§ 228.2 Tier I and tier II annuity components.

(a) *Tier I annuity component.* The Tier I annuity component is generally the amount that would have been payable under the Social Security Act if all of the employee's earnings after 1936 under both the railroad retirement system and the social security system had been creditable under the Social Security Act.

(b) *Tier II annuity component.* The tier II annuity component is the portion of the survivor's annuity which is based on an employee's railroad earnings only. The tier II component of an annuity described in this part is a specified percentage of the employee's actual or anticipated tier II annuity component.

Subpart B—The Tier I Annuity Component

§ 228.10 Computation of the tier I annuity component for a widow(er), disabled widow(er), remarried widow(er), and a surviving divorced spouse.

The tier I annuity component for these beneficiaries is generally based on the survivor tier I Primary Insurance Amount (PIA). The survivor tier I PIA is determined in accordance with section 215 of the Social Security Act using the deceased employee's combined railroad and social security earnings after 1950 (or after 1936 if a higher PIA would result) up to the maximum creditable amounts through the year of the employee's death. See part 225 of this chapter. This amount may be further adjusted for certain reductions or deductions as described in §§ 228.15–228.20 of this part and is subject to the family maximum. See § 228.14 of this part.

§ 228.11 Computation of the tier I annuity component of a widow(er) with a child in care, remarried widow(er) with a child in care, or a surviving divorced spouse with a child in care.

The tier I annuity component of a widow(er), remarried widow(er), or a surviving divorced spouse with a child of the employee in his or her care is 75 percent of the PIA computed under § 228.10 of this part. The amount may be adjusted for certain reductions and deductions described in §§ 228.15–228.20 of this part and is subject to the family maximum. See § 228.14 of this part.

§ 228.12 Computation of the tier I annuity component of a child's insurance annuity.

The tier I annuity component of a child's insurance annuity is 75 percent of the PIA computed under § 228.10 of this part. The amount may be adjusted for the family maximum. See § 228.14 of this part.

§ 228.13 Computation of the tier I annuity component of a parent's insurance annuity.

The tier I annuity component of a parent's insurance annuity is dependent on whether one or two parents are entitled.

(a) *One parent entitled.* A parent's tier I annuity component is equal to 82½ percent of the PIA computed under § 228.10 of this part.

(b) *More than one parent entitled.* A parent's tier I annuity component is equal to 75 percent of the PIA computed under § 228.10 of this part.

(c) The amounts computed under paragraph (a) or (b) of this section may be adjusted for the family maximum. See § 228.14 of this part.

§ 228.14 Family maximum.

(a) *Family maximum defined.* Under the Social Security Act, the amount of total monthly benefits that can be paid for any month on one person's earnings record is limited. This limited amount is called the family maximum. The family maximum is based on the survivor tier I PIA (see part 225 of this chapter). Generally, if three or more persons are entitled to benefits, their benefits will be adjusted for the family maximum.

(b) *Computation of the family maximum*—(1) *The employee attains age 62, has a period of disability or dies prior to 1979.* The maximum is the amount appearing in column V of the applicable table published each year by the Secretary of Health and Human Services on the line on which appears in column IV the primary insurance amount of the insured individual whose compensation is the basis for the benefits payable. Where the total of the survivor benefits exceeds the maximum, the total tier I benefits for each month after 1964 are reduced to the amount appearing in column V. Each survivor's benefit is proportionately reduced, based on the percentage of the PIA used to compute the survivor benefits. However, when any of the persons entitled to benefits on the insured individual's compensation would, except for the limitation described in § 404.353(b)

of title 20 (dealing with the entitlement to more than one child's benefit), be entitled to a child's annuity on the basis of the compensation of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—

(i) The sum of the maximum amounts of benefits payable on the basis of the compensation of all such insured individuals, or

(ii) The last figure in column V of the applicable table published each year by the Secretary of Health and Human Services. The ''applicable table'' refers to the table which is effective for the month the benefit is payable.

(2) *The employee attains age 62, has a period of disability or dies in 1979.* The maximum is computed as follows:

(i) 150 percent of the first $230 of the individual's primary insurance amount, plus

(ii) 272 percent of the primary insurance amount over $230 but not over $332, plus

(iii) 134 percent of the primary insurance amount over $332 but not over $433, plus

(iv) 175 percent of the primary insurance amount over $433.

If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(3) *The employee attains age 62, or has a period of disability or dies after 1979.* The maximum is computed as in paragraph (b)(2) of this section. However, the dollar amounts shown there will be updated each year after 1979 as average earnings rise. This updating is done by first dividing the average of the total wages for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (b)(2) of this section. Each updated dollar amount will be rounded to the nearer dollar, if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1. Before November 2 of each calendar year after 1978, the Secretary of Health and Human Services will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(c) *Special minimum PIA.* Regardless of the method used to compute the primary insurance amount, if the special minimum primary insurance amount described in § 404.261 to this title is higher, then the family maximum will be based upon the special minimum primary insurance amount.

§ 228.15 Reduction for age.

(a) *Widow(er), surviving divorced spouse, or remarried widow(er).* The tier I annuity component is reduced 19/40 of 1 percent multiplied by the number of months before the annuitant attains full retirement age (presently age 65) effective with the annuity beginning date for widow(ers) born before 1/2/40. (For widow(ers) born after 1/1/40, see section 216(l) of the Social Security Act.)

(b) *Disabled widow(er), disabled surviving divorced spouse, or disabled remarried widow(er).* The tier I annuity component is reduced for a maximum of 60 months even though the annuity may begin at age 50.

§ 228.16 Adjustments in the age reduction factor (ARF).

Upon the attainment of retirement age, the previously-computed age reduction factor is adjusted to remove those months for which a full annuity was not paid even though the individual was entitled.

§ 228.17 Adjustments to the widow(er)'s, disabled widow(er)'s, surviving divorced spouse's, and remarried widow(er)'s tier I annuity amount.

(a) If the employee died before attaining age 62 and after 1978 and the widow(er), disabled widow(er), remarried widow(er), or surviving divorced spouse is first eligible after 1984, the Board will compute the tier I annuity amount as if the employee had not died but had reached age 62 in the second year after the indexing year (see § 225.2 of this chapter); *provided, however,* that if the employee was entitled to a primary insurance amount based on average monthly wages this section is not applicable. The indexing year is never earlier than the second year before the

year of the employee's death. Except for this limitation it is the earlier of—

(1) The year the employee attained age 60, or would have attained age 60 had the employee lived, and

(2) The second year before the year in which the widow(er), remarried widow(er), or surviving divorced spouse becomes eligible for such an annuity, has attained age 60, or is age 50–59 and disabled.

(b) The tier I annuity component is increased if the employee's annuity was increased or would have been increased based on delayed retirement credits (see § 225.36 of this chapter).

(c) The tier I annuity component is reduced if the employee had been entitled to an age reduced annuity, including an annuity based on 30 years of service, which is reduced for age because it began before the employee attained age 62. In this instance, the widow(er)'s, remarried widow(er)'s, or surviving divorced spouse's tier I annuity component after applying any reduction for age is further reduced to the larger of amount the employee would have received as a tier I annuity component if still alive or 82½ percent of his or her primary insurance amount.

§ 228.18 Reduction for public pension.

(a) The tier I annuity component of a widow(er), remarried widow(er), surviving divorced spouse, or disabled widow(er) annuity, as described in the preceding sections of this part, is reduced if the survivor is in receipt of a public pension.

(b) *When reduction is required.* Unless the survivor annuitant meets one of the exceptions in paragraph (d) of this section, the tier I annuity component is reduced each month the survivor annuitant is receiving a monthly pension from a Federal, State, or local government agency (Government pension) for which he or she was employed in work not covered by social security on the last day of such employment. For purposes of this section, Federal government employees are not considered to be covered by social security if they are covered for Medicare but are not otherwise covered by social security, or if they are covered under social security solely by an election to become subject to the Federal Employees and Retirement System made after December 31, 1987, and have not worked 60 months under that system.

(c) *Payment in a lump sum.* If the Government pension is not paid monthly or is paid in a lump-sum payment, the Board will determine how much the pension would be if it were paid monthly. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period for the equivalent monthly pension benefit is not clear, it may be necessary for the Board to determine the reduction period on an individual case basis.

(d) *Exceptions.* The reduction does not apply:

(1) If the survivor is receiving a Government pension based on employment for an interstate instrumentality; or

(2) If the survivor receives or is eligible to receive a Government pension for one or more months in the period December 1977 through November 1982 and he or she meets the requirements for social security benefits that were applied in January 1977, assuming the employee's earnings had been covered under that Act (even though he or she did not actually claim such benefits or become entitled for such benefits until a later month). The January 1977 requirements are, for a man, a one-half support test (see paragraph (e) of this section), and, for a woman claiming benefits as a surviving divorced spouse, marriage for at least 20 years to the insured worker. A person is considered eligible for a Government pension for any month in which he or she meets all the requirements for payment except that he or she is working or has not applied; or

(3) If a survivor annuitant was receiving or eligible (as defined in paragraph (d)(2) of this section) to receive a Government pension for one or more months before July 1983, and he or she meets the one-half support test (see paragraph (e) of this section). If a survivor annuitant meets the exception in this paragraph but he or she does not meet the exception in paragraph (d)(2) of this section, December 1982 is the

earliest month for which the reduction will not affect his benefits; or

(4) If a survivor annuitant was eligible for a Government pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, the Board will consider the annuitant to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (d)(2) and (3) of this section. If an annuitant meets an exception solely because of this paragraph, his or her benefits will be unreduced for months after November 1984 only.

(e) *The one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (d)(2) of this section and for a man or a woman to meet the exception in paragraph (d)(3) of this section, he or she must meet a one-half support test. One-half support is defined in part 222 of this chapter. One-half support must be met at one of the following times:

(1) If the employee upon whose compensation the survivor annuity is based had a period of disability which did not end before he or she became entitled to an age and service or disability annuity, or died, the survivor annuitant must have been receiving at least one-half support from the employee—

(i) At the beginning of his or her period of disability; or

(ii) At the time he or she became entitled to an age and service or disability annuity; or

(iii) At the time of his or her death.

(2) If the employee upon whose compensation the survivor annuity is based did not have a period of disability at the time of his or her entitlement or death, the survivor annuitant must have been receiving at least one-half support from the employee—

(i) At the time he or she became entitled to an age and service annuity or disability annuity; or

(ii) At the time of his or her death.

(f) *Amount of reduction.* (1) If a survivor annuitant becomes eligible for a Government pension after June 1983, the Board will reduce (but not below zero) the tier I annuity component by two-thirds of the amount of the monthly pension. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(2) If a survivor annuitant became eligible for a Government pension before July 1983 and he or she did not meet one of the exceptions in paragraph (d) of this section, the Board will reduce (but not below zero) the tier I component by the full amount of the pension for months before December 1984 and by two-thirds the amount of his or her monthly pension for months after November 1984. If the amount of the reduction is not a multiple of 10 cents, it will be rounded to the next higher multiple of 10 cents.

(g) *Reduction not applicable.* This reduction is not applied to claimants who both filed and were entitled to benefits prior to December 1977.

§ 228.19 Reduction for a social security benefit.

The tier I annuity component is reduced for the amount of any social security benefit to which the survivor annuitant is entitled.

§ 228.20 Reduction for an employee annuity.

(a) *General.* If an individual is entitled to an annuity as a survivor, and is also entitled to an employee annuity, then the survivor annuity must be reduced by the amount of the employee annuity. However, this reduction does not apply (except as provided in paragraph (b) of this section) if the survivor or the individual upon whose earnings record the survivor annuity is based worked for a railroad employer or as an employee representative before January 1, 1975.

(b) *Tier I reduction.* If an individual is entitled to an annuity as a survivor, then the tier I component of the survivor annuity must be reduced by the amount of the tier I component of the employee annuity after reduction for age. Where the survivor is entitled to a tier II component and either the survivor or the employee had railroad earnings before 1975, a portion of this reduction may be restored in the computation of the tier II component (see § 228.52 of this part).

§ 228.21 Entitlement as a spouse or divorced spouse and as a survivor.

If an individual is entitled to both a spouse or divorced spouse and survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she may receive the smaller annuity rather than the larger annuity.

§ 228.22 Entitlement to more than one survivor annuity.

If an individual is entitled to more than one survivor annuity, only the larger annuity will be paid. However, if the individual so chooses, he or she may receive the smaller annuity rather than the larger annuity.

§ 228.23 Priority of reductions.

The tier I component of the survivor annuity is first reduced by the family maximum, if applicable, then any applicable age reduction, then by any public pension offset, then by any social security benefit payable, then by the tier I component of any employee annuity payable to the survivor annuitant.

§ 228.40 Cost of living increase applicable to the tier I annuity component.

The tier I annuity component of a survivor annuity is increased at the same time and by the same percentage as the increase provided for under section 215(i) of the Social Security Act. The amount of the increase is published in the FEDERAL REGISTER annually. The cost-of-living increase is payable beginning with the benefit for the month of December of the year for which the increase is due. The increase is paid in the January payment.

Subpart C—The Tier II Annuity Component

§ 228.50 Tier II annuity component widow(er), child, or parent.

(a) *General.* The tier II annuity component is an additional amount payable to a widow(er), disabled widow(er), child, or parent, but not to a surviving divorced spouse or remarried widow(er), and a parent as provided in paragraph (b)(2) of this section, based on the railroad employee's earnings in the railroad industry. Unlike the tier I annuity component it is not reduced for any other social insurance benefit except a railroad retirement annuity. See §§ 228.20–228.23 of this part.

(b) *Amount of the tier II annuity component (1981 amendment)*—(1) *Widow(er) or disabled widow(er).* The amount of a widow(er)'s or disabled widow(er)'s tier II annuity component is 50 percent of the amount of the employee's tier II which would have been payable in the month in which the widow became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time.

(2) *Parent.* The amount of a parent's tier II annuity component is 35 percent of the amount of the employee's tier II annuity component which would have been payable in the month in which the parent became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time. However, if another survivor is entitled, or potentially entitled, to a tier II annuity component, the parent tier II annuity component is zero.

(3) *Child.* The amount of each child's tier II annuity component is 15 percent of the employee's tier II annuity component which would have been payable in the month in which the child became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time.

(c) *Minimum tier II survivor annuity components.* If the total tier II annuity components payable to survivors is less than 35 percent of the employee's tier II annuity component which would have been payable in the month the survivors became entitled had the employee been alive and in receipt of an annuity under the Railroad Retirement Act at that time, the individual tier II annuity components computed in paragraph (b) of this section shall be increased proportionally so that the total of all such tier II annuity components equals 35 percent of the employee's tier II annuity component.

(d) *Maximum tier II annuity components.* If the total tier II survivor annuity components payable to survivors exceeds 80 percent of the employee's tier II annuity component which would

have been payable in the month the survivors became entitled had the employee been alive and entitled to an annuity under the Railroad Retirement Act at that time, the individual tier II annuity components computed in paragraph (b) of this section shall be reduced proportionally so that the total of all such tier II annuity components totals no more than 80 percent of the employee's tier II annuity component.

(e) *Age reduction.* The tier II annuity component of a widow(er) or disabled widow(er) is subject to reduction by the same age reduction factor as is applicable to the tier I annuity component. See § 228.15 of this part.

§ 228.51 Takeback amount.

(a) The 1983 amendments to the Railroad Retirement Act provided that a portion of the cost-of-living increases payable on the tier I annuity component be offset from the amount of the tier II annuity. This amount is the takeback amount. The amount of the takeback and its application depends on the employee and survivor's annuity beginning dates.

(b)(1) The tier II takeback amount for survivors whose annuity beginning date is January 1, 1984 or later is usually the amount of the employee's takeback amount. That amount is equal to 5 percent of the employee's primary insurance amount, less all applicable reductions (net tier I), on November 1, 1983. However, if the employee's annuity was reduced for a social security benefit but the survivor's annuity is not, the takeback amount is the amount the employee's annuity would have been reduced for the takeback if the employee's annuity had not been reduced for a social security benefit. If the employee's annuity had not been tiered or was being paid under the overall minimum, the Board will compute the amount of the tier II takeback that would have been applicable to the employee's annuity.

(2) The tier II takeback amount for survivors whose annuity beginning date is before January 1, 1984 is equal to 5 percent of the survivor's net tier I annuity component, before deduction on account of work, on November 1, 1983.

(3) The tier II takeback will be applied in accord with the above paragraphs in any case where the employee died or retired before January 1, 1984. If the employee died or retires after December 31, 1983, or the employee never retired and dies after December 31, 1993, no takeback will be applied to the survivor's annuity.

(c) No takeback is applied if the survivor tier II annuity amount before the takeback is applied is $10.00 or less and cost-of-living increases have not increased the tier II annuity amount to more than $10.00 (the takeback may never reduce the tier II to an amount less than $10.00).

§ 228.52 Restored amount.

(a) *General.* A restored amount is added to the tier II annuity component of a widow(er)'s annuity whose annuity is reduced for receipt of an employee annuity under the Railroad Retirement Act provided either the employee or the widow(er) had ten years of creditable railroad service prior to January 1, 1975.

(b) *Amount.* The amount of the tier II restored amount for a widow(er) is the difference between the amount payable as a widow(er) under the Railroad Retirement Act of 1937 as increased by all annual social security cost-of-living percentage increases from January 1, 1975, until the later of the annuity beginning date of either the employee's annuity or the widow(er)'s annuity and the amount payable to the widow(er) under the Railroad Retirement Act of 1974 under the rules set forth in this part.

(c) *Widower.* In order to qualify for an annuity under the 1937 Act and thus for a restored amount, a widower must have been dependent on his spouse for at least 50 percent of his support in the year prior to her death or at the time the spouse's annuity began.

§ 228.53 Spouse minimum guarantee.

The Railroad Retirement Act provides that a spouse should receive no less as a widow(er) than he or she received as a spouse. However, if the widow(er) becomes entitled to a social security benefit, thus reducing his or her annuity, the spouse minimum guarantee is payable only to the extent

that it guarantees the amount that the widow(er) would have received as a spouse had he or she been entitled to a social security benefit in the month preceding the employee's death in an amount equal to the amount of the social security benefit payable at the time the widow(er) first became entitled to the social security benefit.

§ 228.60 Cost-of-living increase.

The tier II annuity component of a survivor annuity under the Railroad Retirement Act is increased by 32.5 percent of the percentage increase under section 215(i) of the Social Security Act at the same time that any such increase is payable. The amount of the increase is published in the FEDERAL REGISTER annually. The cost-of-living is payable beginning with the benefit payable for the month of December of the year for which the increase is due. The increase is paid in the January payment. In addition, in determining the amount of the tier II component at the time the survivor annuity begins, all cost-of-living increases that were applied or would have been applied after the employee's annuity beginning date or death and prior to the surviving annuity beginning date are taken into consideration.

PART 229—SOCIAL SECURITY OVERALL MINIMUM GUARANTEE

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Subpart A—General

§ 229.1 Introduction.

This part explains when an annuity can be increased under the social security overall minimum guarantee, also sometimes referred to as the ''special guaranty'', and how the increased amount is determined. Deductions and reductions in the overall minimum rate are explained.

§ 229.2 Definitions.

The following definitions are used in this part:

Annuity means a payment under the Railroad Retirement Act due and payable to an entitled claimant for a calendar month and made to him or her on the first day of the following month. The recipient of an annuity is called an annuitant.

Average Indexed Monthly Earnings or AIME means the average of the employee's monthly creditable earnings in both railroad and social security covered employment in the years used in computing the Primary Insurance Amount, after the earnings are adjusted or ''indexed''. The indexing is a means of expressing prior years earnings in terms of their current dollar value. It is based on increases in the average wages of all wage earners from 1951 although the second year before the year the worker dies or becomes eligible for benefits.

Contribution and benefit base means the maximum earnings used in computing a social security benefit under section 230 of the Social Security Act.

1974 Act means the Railroad Retirement Act approved October 16, 1974, including all amendments.

Railroad formula rate means the amount computed in accord with the regular railroad computations (sections 3(a), 3(b) and 3(h) of the Railroad Retirement Act).

Retirement age means age 65, with respect to an employee or spouse who attains age 62 before January 1, 2000 (age 60 in the case of a widow(er), remarried widow(er) or surviving divorced spouse). For an employee or spouse who attains age 62 (or age 60 in the case of a widow(er), remarried widow(er), or surviving divorced spouse) after December 31, 1999, retirement age means the age provided for in section 216(l) of the Social Security Act.

§ 229.3 Other regulations related to this part.

This part is related to a number of other parts of this chapter (listed numerically):

Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

Part 217 describes how to apply for an annuity or for lump-sum payments.

Part 218 sets forth the beginning and ending dates of annuities.

Part 219 sets out what evidence is necessary to prove eligibility and the relationships described in this part.

Part 220 describes when a person is eligible for a disability annuity under the Railroad Retirement Act or a period of disability under the Social Security Act.

Part 222 describes the family relationships which may cause an annuity to be increased under this part.

Part 225 explains how Primary Insurance Amounts (PIA's) are computed.

§ 229.4 Applying for the overall minimum.

The Board may require an annuitant to provide information regarding his or her family and regarding his or her earnings from employment and self-employment in order to determine

whether the claimant or annuitant qualifies for the overall minimum.

(Approved by the Office of Management and Budget under control number 3220–0083)

Subpart B—Social Security Overall Minimum Guarantee Defined

§ 229.10 What the social security overall minimum guarantee is.

The social security overall minimum guarantee is the amount of total family benefits which would be paid under the Social Security Act if the employee's railroad service had been covered by that Act. A 100 percent overall minimum benefit may be paid, as described in § 229.11. A 100 percent overall minimum based on age (age O/M) may be payable when the employee is 62 years old. The age O/M is reduced for age for months in which the O/M is payable before the employee attains retirement age. An overall minimum may also be payable before age 62 based on an employee's disability (DIB O/M). The DIB O/M is not reduced for age.

§ 229.11 100 percent overall minimum.

Section 3(f)(3) of the 1974 Act guarantees that the total annuities payable to the employee and spouse, including the vested dual benefits but not including a supplemental annuity, will not be less than 100 percent of the total family benefits payable under the Social Security Act if the employee's railroad service after 1936 were credited as social security earnings. Subpart F describes how the 100 percent overall minimum rate is computed.

Subpart C—Eligibility for Increase Under the Overall Minimum

§ 229.20 When an employee is eligible for an increase under the overall minimum.

(a) *Overall minimum based on age.* An employee annuity can be increased under the age O/M if all the following conditions are met:

(1) The employee is entitled to an age or disability annuity as shown in part 216 of this chapter.

(2) The employee is at least 62 years old throughout the whole month. The O/M is reduced for each month it is payable before the month the employee attains retirement age.

(3) The employee is fully insured under section 214 or 227 of the Social Security Act based on railroad and social security earnings.

(b) *Overall minimum based on disability.* An employee annuity can be increased under the DIB O/M if the employee is under retirement age, and

(1) Is entitled to an age or disability annuity; and

(2) Is disabled under § 404.1505 of this title; and

(3) Is insured for a disability benefit under § 404.130 of this title based upon combined railroad and social security earnings.

(c) *Spouse with child in care or spouse retirement age or older.* If the employee has not attained the age required to qualify the spouse for a spouse annuity but the employee meets the conditions of paragraph (a) or (b) of this section, the employee annuity can be increased under the overall minimum if:

(1) The employee and spouse complete the required statements concerning the family and earnings as provided for in § 229.4 of this part; and

(2) The spouse meets the marriage requirements as provided for in part 222 of this chapter; and

(3) The spouse has an eligible child in care, or the spouse is retirement age or older.

(d) *Spouse election.* If the employee has not attained the age required to quality the spouse for a spouse annuity but the employee meets the conditions of paragraph (a) or (b) of this section, the employee annuity can be increased under the overall minimum if:

(1) The employee and spouse complete the required statements concerning the family and earnings as provided for in § 229.4 of this part; and

(2) The spouse meets the marriage requirements as provided for in part 222 of this chapter; and

(3) The spouse is between age 62 and retirement age and does not have a child in care; and

(4) The spouse files an election to be included.

§ 229.21 When a spouse is eligible for an increase under the overall minimum.

Normally, only the employee annuity receives the amount of the overall minimum increase. However, a spouse annuity may be increased under the O/M in cases in which the O/M benefit amount exceeds the total amount of the employee and spouse annuity.

§ 229.22 Beginning date of increase under overall minimum.

(a) *Employee age O/M.* An increase under the overall minimum in an employee annuity based on age can be paid beginning with the later of:

(1) The first day of the first full month throughout which the employee is age 62; or

(2) The beginning date of the employee's age or disability annuity; or

(3) The first month of the quarter in which the employee becomes insured under section 214 or 227 of the Social Security Act based on railroad and social security earnings; or

(4) The month the employee attains retirement age, if a DIB O/M was paid in the previous month. A DIB O/M is changed to an age O/M in the month the employee attains retirement age.

(b) *Employee DIB O/M.* An increase under the overall minimum in an employee annuity based on disability can be paid beginning with the later of—

(1) The beginning date of the employee's disability annuity; or

(2) The month after the month in which the disability waiting period described in § 404.315(d) of this title ends; or

(3) If no disability waiting period is required, the first month in which the employee is disabled and is insured for a disability benefit under § 404.130 of this title.

(c) *Spouse.* An increase in a spouse annuity under the overall minimum can be paid on the later of:

(1) The date the increase in the employee's annuity is paid; or

(2) The date the spouse is both eligible under the O/M and entitled to a spouse annuity.

Subpart D—Family Members Included in Overall Minimum Computation

§ 229.30 Who can be included in the computation of an annuity under the overall minimum.

(a) *Spouse.* In order to be included as a spouse in the computation of the overall minimum rate, a person must be the employee's wife or husband, as defined in part 222 of this chapter, as of the date described in § 229.31 of this part. The spouse must also be 62 years or older throughout the whole month in which he or she is first included or have the employee's child who is under 16 years old or disabled (before attaining age 22) in his or her care. If a spouse is 62 years old or older and under retirement age, and does not have an eligible child in his or her care, the spouse will be included only if he or she requests the payment of a reduced spouse annuity.

(b) *Child.* In order to be included as a child in the computation of the overall minimum, a person must meet the following requirements as of the date described in § 229.32 of this part. The person must be:

(1) The employee's child as defined in part 222 of this chapter; and

(2) Dependent on the employee, as shown in part 222 of this chapter; and

(3) Not married; and either

(4) Under 18 years old, or 18 years old to 19 years old and a full-time student, as defined in part 216 of this chapter, or 18 years old or older and disabled for any regular employment (see part 220 of this chapter) before attaining age 22.

(c) *Divorced spouse.* In order to be included as a divorced spouse in the computation of the overall minimum, a person must be eligible for a benefit as a divorced spouse under the Railroad Retirement Act as of the date described in § 229.33 of this part.

§ 229.31 When a spouse can be included in the computation of the overall minimum rate.

(a) A spouse who is married to the employee when the employee's application is filed can be included in the computation of the overall minimum rate beginning in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity under the overall minimum, as shown in § 229.22 of this part; or

(2) The spouse first becomes eligible to be included under the overall minimum, as shown in § 229.30 of this part.

(b) A spouse who marries the employee after the employee application is filed can be included in the overall minimum computation in the month in which he or she becomes eligible, as shown in § 229.30 of this part, if the overall minimum rate is already payable in the previous month. If the railroad formula rate is payable in the month before the spouse becomes eligible, the spouse can be included in the overall minimum computation in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22; or

(2) The spouse annuity begins.

§ 229.32 When a child can be included in the computation of the overall minimum rate.

A child who meets the requirements of § 229.30(b) of this part can be included in the computation of the overall minimum rate in the month in which:

(a) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22 of this part; or

(b) In the case of a child born or adopted by the employee after the employee's annuity beginning date, such child can be included only when the overall minimum rate is already payable in the month before the month in which the child is born, or adopted except where:

(1) The child is born or adopted prior to the employee's attaining age 62 or becoming eligible for a period of disability (see § 220.36 of this chapter); or

(2) The child who is adopted after the employee's annuity beginning date meets the dependency requirements set forth in § 222.53 of this chapter.

(c) In the case of a child who has attained age 18 and has become re-entitled as a full-time student or disabled child, as described in § 229.30 of this part, such child can only be included when the overall minimum rate is already payable in the month before the month the child becomes re-entitled.

§ 229.33 When a divorced spouse can be included in the computation of the overall minimum rate.

A divorced spouse annuitant can be included in the computation of the overall minimum rate in the later of the month in which:

(1) The employee first is eligible for an increase in his or her annuity rate under the overall minimum, as shown in § 229.22; or

(2) The divorced spouse annuity begins.

Subpart E—When Entitlement Under the Overall Minimum Ends

§ 229.40 When an annuity increase under the overall minimum ends.

(a) *Employee Age O/M.* An increase in an employee's annuity under the overall minimum based on age ends with the month before the month in which the employee dies. If a disability annuity is increased under the overall minimum based on age rather than disability, and the employee is under retirement age, the increase ends with the second month after the month the disability ends as shown in part 220 of this chapter.

(b) *Employee DIB O/M.* An increase in an employee's annuity under the overall minimum based on disability ends with the earlier of:

(1) The month before the month in which the employee dies; or

(2) The month before the month the employee attains retirement age (the DIB O/M is changed to an age O/M); or

(3) The second month after the month the disability ends, as explained in part 220 of this chapter.

(c) *Spouse.* An increase in a spouse annuity under the overall minimum ends when the increase in the employee annuity ends, as shown in paragraphs (a) and (b) of this section, when the spouse can no longer be included in computing the annuity rate under the overall minimum as shown in § 229.41 of this part, or when the spouse annuity ends as shown in part 218 of this chapter.

§ 229.41 When a spouse can no longer be included in computing an annuity rate under the overall minimum.

A spouse's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the spouse dies; or

(b) The month before the month in which the spouse's marriage to the employee legally terminates; or

(c) If the spouse has an eligible child in care, the earlier of the month before the month in which the child leaves the spouse's care, attains age 16 and is not disabled, or, if disabled, recovers from being disabled; or

(d) The month before the month the employee dies.

§ 229.42 When a child can no longer be included in computing an annuity rate under the overall minimum.

A child's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the child dies; or

(b) The month before the month in which the child marries; or

(c) The month before the month the child becomes 18 years old, unless the child is disabled or a full-time student, as shown in part 216 of this chapter; or

(d) The second month after the month the child's disability ends, if the child is 18 years old or older, and not a full-time student; or

(e) The month in which a student child's annuity would end, as shown in part 218 of this chapter, if the child is 18 years old or older, a full-time student in an elementary or secondary school, and not disabled; or

(f) The month before the month the child becomes entitled to an overall minimum benefit or child's annuity on another earning record, if including the child on the other earnings record would result in higher monthly benefits; or

(g) In the case of a stepchild of the employee, the month after the month in which the divorce between the stepparent and the natural parent becomes final.

[58 FR 53397, Oct. 15, 1993, as amended at 62 FR 47138, Sept. 8, 1997]

§ 229.43 When a divorced spouse can no longer be included in computing an annuity under the overall minimum.

A divorced spouse's inclusion in the computation of the overall minimum rate ends the earlier of:

(a) The month before the month in which the divorced spouse dies; or

(b) The month before the month the employee dies; or

(c) The month before the month in which the divorced spouse remarries; or

(d) The month before the month in which the divorced spouse becomes entitled to a retirement or disability benefit under the Social Security Act based upon a primary insurance amount which is equal to or exceeds the divorced spouse annuity before reduction for age.

Subpart F—Computation of the Overall Minimum Rate

§ 229.45 Employee benefit.

The original employee 100 percent overall minimum amount, before adjustment for age, other family members, or other benefits, is the Overall Minimum PIA, as described in part 225 of this chapter. This is the PIA which would be used under the Social Security Act if the employee's railroad service had been covered under that Act instead of the Railroad Retirement Act. The Overall Minimum PIA may be recomputed for additional earnings and adjusted for cost-of-living increases. Delayed retirement credits are added to the Overall Minimum PIA as shown in part 225, subpart D of this chapter.

§ 229.46 Spouse or divorced spouse benefit.

If a spouse or divorced spouse is included in the computation of the overall minimum, a benefit of 50 percent times the Overall Minimum PIA is computed. In the case of a spouse, the benefit may be adjusted for the family maximum, age, or other benefits. In the case of a divorced spouse, the benefit may be adjusted only for age or other benefits.

§ 229.47 Child's benefit.

If a child is included in the computation of the overall minimum, a child's benefit of 50 percent times the Overall Minimum PIA is computed. This amount may be adjusted for the family maximum or other benefits.

§ 229.48 Family maximum.

(a) *Family maximum defined.* Under the Social Security Act, the amount of monthly benefits that can be paid for any month on one person's earnings record is limited. This limited amount is called the family maximum. The family maximum used to adjust the social security overall minimum rate is based on the employee's Overall Minimum PIA. The divorced spouse overall minimum is never reduced because of the family maximum.

(b) *Computation of the family maximum*—(1) *The employee attains retirement age prior to 1979.* The maximum is the amount appearing in column V of the applicable table published each year by the Secretary of Health and Human Services on the line on which appears in column IV the primary insurance amount of the insured individual whose compensation is the basis for the benefits payable. Where the maximum is exceeded, the total tier I benefits for each month after 1964 are reduced to the amount appearing in column V. However, when any of the persons entitled to benefits on the insured individual's compensation would, except for the limitation described in § 404.353(b) of title 20 (dealing with the entitlement to more than one child's benefit), be entitled to a child's annuity on the basis of the compensation of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of:

(i) The sum of the maximum amounts of benefits payable on the basis of the compensation of all such insured individuals, or

(ii) The last figure in column V of the applicable table published each year by the Secretary of Health and Human Services. The ''applicable'' table refers to the table which is effective for the month the benefit is payable.

(2) *The employee attains retirement age in 1979.* (i) The maximum is computed as follows:

(A) 150 percent of the first $230 of the individual's primary insurance amount, plus

(B) 272 percent of the primary insurance amount over $230 but not over $332, plus

(C) 134 percent of the primary insurance amount over $332 but not over $433, plus

(D) 175 percent of the primary insurance amount over $433.

(ii) If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(3) *The employee attains retirement age after 1979.* The maximum is computed as in paragraph (b)(2) of this section. However, the dollar amount shown there will be updated each year as average earnings rise. This updating is done by first dividing the average of the total wages (see 20 CFR 404.203(m)) for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (b)(2) of this section. Each updated dollar amount will be rounded to the nearer dollar, if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1. Before November 2 of each calendar year after 1978, the Secretary of Health and Human Services will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(c) *Disability family maximum.* If an employee's first month of entitlement to the DIB O/M is July 1980 or later, the family maximum is 85 percent of the employee's Average Indexed Monthly Earnings but not less than the employee's Overall Minimum PIA, and no more than 150 percent of the employee's Overall Minimum PIA.

(d) *Reduction for family maximum.* The spouse's and child(ren)'s share of the Overall Minimum PIA are reduced if the total benefits are higher than the family maximum amount. These auxiliary shares are adjusted so that they each receive a proportionate share of the family maximum amount over and above the employee benefit. This adjustment is before adjustment for age

or other benefits. The spouse and child(ren)'s benefits are computed as follows:

(1) The Overall Minimum PIA is subtracted from the family maximum amount.

(2) The result from paragraph (d)(1) of this section is divided by the total number of auxiliary beneficiaries (spouse and children).

(3) If the amount of each benefit from paragraph (d)(2) of this section is not a multiple of $0.10, it is rounded to the next lower multiple of $0.10. After determining the beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(e) *Combined family maximum.* If a child is eligible to be included in the computation of the overall minimum on more than one railroad retirement annuity, a combined family maximum may apply, if it results in higher annuity rates. The combined family maximum is the smaller of:

(1) The sum of the individual family maximums on each earnings record; or

(2) 1.75 times the highest primary insurance amount possible in a year using average indexed monthly earnings equal to one-twelfth of the contribution and benefit base for that year. Average indexed monthly earnings and contribution and benefit base are explained in § 229.2 of this part.

(f) This section may be illustrated by the following examples:

(1) An employee, age 62, applies for an age and service annuity under the Railroad Retirement Act (RRA). His annuity rate is $700. The employee has a son who was disabled for all regular employment prior to his attaining age 18. The RRA does not provide an annuity for a disabled child of a living employee. If the employee had been covered under the Social Security Act he would have received a benefit of $500 (the Overall Minimum PIA) and his child would have received a benefit of $250 (50 percent of $500), which produces a total family benefit of $750. The family maximum is $804.90. Under the O/M guarantee, the employee would receive $750 since it is higher than his annuity rate of $700. Since $750 is less than the family maximum computed for this employee, there is no reduction for the family maximum.

(2) It is determined that a disabled employee is entitled to a DIB O/M computed as follows:

Overall Minimum PIA	$ 600.00
Spouse (50% × 600)	300.00
Child (50% × 600)	300.00
	1200.00

However, the employee's family maximum is $900 (150 percent of $600). Consequently, the DIB O/M will be paid as follows:

Employee	$ 600.00
Spouse	150.00
Child	150.00
	900.00

§ 229.49 Adjustment of benefits under family maximum for change in family group.

(a) *Increase in family group.* If an overall minimum rate is adjusted for the family maximum and an additional family member can be included, the benefits payable to previous auxiliary beneficiaries (spouse and children) are reduced to provide a share for the new family member. The difference between the Overall Minimum PIA (see § 225.15 of this part) and the family maximum amount is divided by the increased number of auxiliary beneficiaries. If the amount of each benefit is not a multiple of $0.10, it is rounded to the next lower multiple of $0.10. After determining a beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(b) *Decrease in family group.* If an overall minimum rate is adjusted for the family maximum and there is a decrease in the number of eligible family members, the benefits for the remaining auxiliary beneficiaries (spouse and children) are increased. If the family maximum still applies, the difference between the Overall Minimum PIA and the family maximum amount is divided by the number of remaining auxiliary beneficiaries. If the amount of each benefit is not a multiple of $0.10, it is rounded to the next lower multiple of

$0.10. After determining the beneficiary's share (the amount after reduction for other benefits) the amount is rounded to the next lowest multiple of $1.00, if it is not already a multiple of $1.00.

(c) *Effective date of rate change.* The overall minimum rate changes described in paragraphs (a) and (b) of this section are effective the month in which the number of auxiliary beneficiaries changes.

§ 229.50 Age reduction in employee or spouse benefit.

(a) *When age reduction applies.* The employee overall minimum benefit is reduced for each month the employee is under retirement age on the date the employee becomes eligible for an increase under the overall minimum, as shown in § 229.22 of this part, unless the employee has a period of disability and § 229.52 of this part does not apply, in which case no age reduction is applied. The spouse overall minimum benefit is reduced for each month a spouse, who is not a spouse with the employee's child under 16 years old or disabled before attaining age 22 in his or her care, is under retirement age on the date the spouse is eligible for an increase under the overall minimum (see § 229.21 of this part). If a spouse's overall minimum benefit is reduced for age and he or she later begins caring for an eligible child, no age reduction will apply for the months the child is in his or her care.

(b) *Employee age reduction.* The Overall Minimum PIA plus any delayed retirement credits is reduced by 1/180 for each month the employee is under retirement age on the date the employee becomes eligible for the overall minimum. When the PIA amount is increased, the amount of the increase is reduced by 1/180 for the same number of months used to determine the initial age reduction.

(c) *Spouse age reduction.* The amount of the spouse overall minimum benefit, after any adjustment for the family maximum, is reduced by 1/144 for each month the spouse is under retirement age on the date when he or she becomes eligible under the overall minimum. When the spouse benefit increases, the amount of the increase is reduced by 1/144 for the same number of months used to compute the initial age reduction.

(d) *Age reduction after 1999.* Beginning in the year 2000 the amount of age reduction shall be as specified in paragraphs (b) and (c) of this section for the first 36 months of the reduction period, as defined in paragraph (e) of this section, and 1/240 for any additional months included in such period.

(e) *Reduction period defined.* The reduction period is the number of months beginning with the first month for which the O/M is payable and ending with the month before the month the beneficiary attains retirement age.

§ 229.51 Adjustment of age reduction.

(a) *General.* If an age reduced employee or spouse overall minimum benefit is not paid for certain months before the employee or spouse attains retirement age, or the employee becomes entitled to a DIB O/M, the age reduction may be adjusted to drop the months for which no payment was made or the overall minimum rate was not reduced for age.

(b) *Employee adjusted age reduction.* The following months are deducted from the months used to determine the age reduction in the Overall Minimum PIA amount, effective the month in which the employee attains retirement age or becomes entitled to a DIB O/M:

(1) Months in which the increase under the overall minimum is completely or partially deducted because of the employee's excess earnings; and

(2) Months in which the employee is entitled to a DIB O/M as well as a reduced O/M.

(c) *Spouse adjusted age reduction.* The following months are deducted from the months used to determine the age reduction in the spouse overall minimum benefit, effective the month in which the spouse attains retirement age:

(1) Months in which the spouse O/M benefit is completely or partially deducted because of the employee's or spouse's excess earnings:

(2) Months after entitlement to a spouse O/M benefit ends for any reason;

(3) Months in which a spouse has in her care the employee's child who is

under 16 years old or disabled before age 22;

(4) Months in which a DIB O/M benefit is not payable because the employee refused rehabilitation service (see § 229.81 of this part).

§ 229.52 Age reduction when a reduced age O/M is effective before DIB O/M.

If an employee received a reduced age O/M before the effective date of a DIB O/M, the PIA amount for the DIB O/M is reduced as if the employee had attained retirement age on the effective date of the DIB O/M.

§ 229.53 Reduction for social security benefits on employee's wage record.

The total annuity rate under the overall minimum is reduced, but not below zero, by the total amount of the social security benefits being paid to all family members on the employee's wage record.

§ 229.54 Reduction for social security benefit paid to employee on another person's earnings record.

The employee PIA amount under the overall minimum, after any age reduction, is reduced, but not below zero, by the amount of any social security benefit being paid to the employee on another person's earnings record.

§ 229.55 Reduction for spouse social security benefit.

A spouse benefit under the overall minimum, after any adjustment for the family maximum and for age, is reduced, but not below zero, by the amount of any social security benefit being paid to the spouse on other than the employee's earnings record. If the social security benefit is equal to or higher than the spouse overall minimum benefit and the family maximum applies, the overall minimum rate is recomputed so that the spouse is not included, if it would result in a higher overall minimum rate.

§ 229.56 Reduction for child's social security benefit.

A child's benefit under the overall minimum, after any adjustment for the family maximum, is reduced, but not below zero, by the amount of any social security benefit being paid to the child on other than the employee's earnings record. If the social security benefit is equal to or higher than the child's overall minimum benefit and the family maximum applies, the overall minimum rate is recomputed so that the child is not included, if it would result in a higher overall minimum rate.

§ 229.57 Reduction in spouse overall minimum benefit for employee annuity.

If an annuitant is entitled to both an employee annuity on his or her own earnings record and a spouse annuity on a different earnings record, the total overall minimum rates on both earnings records must be higher than the total railroad formula rates for the overall minimum to apply. The spouse overall minimum benefit amount, after adjustment for the family maximum and for age, is reduced by the employee-only overall minimum rate on the spouse's own earnings record (the employee benefit adjusted for age and social security benefits) plus the amount of any social security benefit payable to the spouse on other than the empoyee's earnings record.

§ 229.58 Rounding of overall minimum amounts.

The overall minimum amount for each beneficiary which is not a multiple of $0.10 is rounded to the next lower multiple of $0.10. After reducing each beneficiary's share for other benefits, if the result is not a multiple of $1.00 it is rounded to the next lower multiple of $1.00.

Subpart G—Reduction for Worker's Compensation or Disability Benefits Under a Federal, State, or Local Law or Plan

§ 229.65 Initial reduction.

(a) *When reduction is effective.* A benefit computed under the overall minimum based on disability (DIB O/M) is reduced (not below zero) for any month the employee is under retirement age and is entitled to worker's compensation or disability benefits under a Federal, State, or local law or plan (public disability benefit). The reduction is effective with the month the employee is

entitled to worker's compensation or a public disability benefit.

(b) *When reduction is not made.* A reduction for worker's compensation is not made if the law or plan under which the worker's compensation or public disability benefit is paid provides for the reduction of the benefit provided due to entitlement to a social security disability benefit, and so provided on February 18, 1981.

(c) *Amount of reduction.* The reduction in the DIB O/M for worker's compensation or public disability benefit equals the difference between:

(1) The sum of the monthly DIB O/M rate, including benefits for all family members (subject to the family maximum), plus the monthly worker's compensation or public disability benefit; and

(2) The higher of 80 percent of the employee's average current earnings before becoming disabled or the monthly DIB O/M rate (before reduction for worker's compensation or public disability benefit).

(d) *Average current earnings, defined.* Beginning January 1, 1979, an employee's average current earnings for purposes of this section are the highest of:

(1) The average monthly wage (see § 225.2 of this chapter) used to compute the DIB O/M under the Social Security Act rules which were in effect before 1979; or

(2) One-sixtieth of the employee's total earnings from employment or self-employment under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum used in computing social security benefits) for the 5 consecutive years after 1950 in which the earnings were the highest; or

(3) One-twelfth of the employee's total earnings from employment or self-employment under either the Social Security or Railroad Retirement Acts (including earnings that exceed the maximum used in computing social security benefits) for the year of highest earnings in the period from 5 years before through the year in which the employee became disabled. The result is rounded to the next lower multiple of $1.00.

§ 229.66 Changes in reduction amount.

(a) *Change in DIB O/M.* The amount of the worker's compensation or public disability benefit reduction does not change when there is an increase in the DIB O/M rate because of an amendment or cost of living increase. However, the reduction amount does change if there is a change in the family members included in the DIB O/M. When the number of family members changes and the DIB O/M is still payable, the amount of the reduction is recomputed using the DIB O/M rate, including the changed family group, as if the new family composition had existed when the worker's compensation or public disability benefit reduction first applied. However, this new reduction is not effective until the date of the change of the family group. The worker's compensation or public disability benefit and average current earnings are the same as those used before the change in the family group.

(b) *Change in amount of worker's compensation/public disability benefit.* The amount of the reduction for worker's compensation or public disability benefit changes when there is a change in the amount of the worker's compensation or public disability benefit. If the worker's compensation or public disability benefit increases, the change in the reduction amount is effective with the month of the increase. If the worker's compensation or public disability benefit decreases, the change in the reduction amount is effective with the month of the decrease, no matter when the notice of the decrease is received.

§ 229.67 Redetermination of reduction.

(a) *General.* All cases reduced for worker's compensation or public disability benefit are recomputed in the second year after the year the reduction was first applied and every third year after that. The redetermined rate is effective with January of the year after the year the redetermination is made. The redetermined reduction is used only if it provides an annuity rate that is higher than the previous annuity rate.

(b) *Redetermined average current earnings.* The average current earnings amount used in redetermining a worker's compensation or public disability

benefit reduction is determined by multiplying the initial average current earnings amount by:

(1) The average total wages (including wages that exceed the maximum used in computing social security benefits) of all persons for whom wages were reported to the Secretary of the Treasury for the year before the year or redetermination, divided by the average total wages for 1977 or, if later, the year before the year the reduction was first computed. If the result is not a multiple of $1.00, it is rounded to the next lower multiple of $1.00; or

(2) If the reduction was first computed before 1978, the average taxable wages reported to the Secretary of Health and Human Services for the first quarter of 1977, divided by the average taxable wages for the first quarter of the year before the year the reduction was first computed. If the result is not a multiple of $1.00, it is rounded to the next lower multiple of $1.00.

§ 229.68 Reduction of DIB O/M.

A reduction for entitlement to worker's compensation or a public disability benefit is applied after the DIB O/M is reduced for age and the family maximum. The spouse and child O/M benefits are first reduced proportionately. The employee O/M benefit is decreased by any remaining reduction amount.

Subpart H—Miscellaneous Deductions and Reductions

§ 229.80 Earnings restrictions.

The O/M may be reduced due to earnings from employment or self-employment in the same manner as a social security benefit. These restrictions on earnings are found at subpart E of part 404 of this chapter. Earnings can never reduce an employee's benefit below the railroad formula rate less the amount that those benefits would be reduced by earnings.

§ 229.81 Refusal to accept vocational rehabilitation.

The DIB O/M is not payable for any month in which the disabled employee refuses, without good reason, to accept vocational rehabilitation services available under an approved state program. A disabled child's benefit under the O/M is not payable for any month in which the child refuses, without good reason, to accept such vocational rehabilitation services, unless the child is a full-time student.

§ 229.82 Failure to have child in care.

(a) *General.* The full amount of the spouse overall minimum benefit is not payable for any month a spouse, who is included in the overall minimum because he or she has a child in his or her care, is under retirement age and is no longer caring for an eligible child. However, if the spouse is at least 62 years old, a reduced spouse annuity or a reduced overall minimum benefit is payable if the spouse has stated that he or she will accept a reduced benefit.

(b) *Report required.* When the overall minimum, which includes a benefit for a spouse who has the employee's child in his or her care, is payable, both the employee and spouse are responsible for reporting when the child leaves the spouse's care. The report is due before the benefits are paid for the second month after the first month in which the child is no longer in the spouse's care.

(c) *Penalty for failure to report.* If the employee or spouse does not report the fact that a spouse included in the overall minimum no longer has an eligible child in his or her care within the time limit shown in paragraph (b) of this section, a penalty is deducted from the overall minimum amount, unless there is a good reason for the person's failure to report. The penalty deduction for the first failure to make a timely report equals the amount of the overall minimum increase for the first month in which a report should have been made. The deduction for the second failure to make a timely report is twice the amount of the overall minimum increase for the first month in which a report should have been made. The deduction for the third and later failures to make a timely report is three times the amount of the overall minimum increase for the first month in which a report should have been made or, if less, the overall minimum increase times the number of months for which a timely report was not made.

§ 229.83 Deportation.

The age DIB O/M is not payable for any month after the month the Board receives notice that the employee has been deported for a reason shown in section 202(h) of the Social Security Act. This restriction no longer applies if the employee is later legally admitted to the United States for permanent residence.

§ 229.84 Conviction for subversive activities.

If a person is convicted of subversive activities (under chapter 37, 105, or 115 of title 18 of the U.S. Code or section 4, 112, or 113 of the Internal Security Act of 1950, as amended), the court may order that earnings in the year of the conviction and previous years are to be disregarded in determining whether the person is entitled to social security benefits. These earnings would also be ignored in determining entitlement to the age or DIB O/M.

§ 229.85 Substantial gainful activity by blind employee or child.

A blind employee or child who is 55 years old or older is entitled to an O/M benefit based on disability while he or she is working in substantial gainful activity that does not require skills or ability used in his or her previous work. However, the DIB O/M or child's O/M benefit is not payable for any month in which the employee or child works in any type of substantial gainful activity which requires skills or abilities comparable to those of any gainful activity in which he or she has previously engaged with some regularity and over a substantial period of time.

Subpart I—Payment of Overall Minimum Rate

§ 229.90 Proportionate shares of overall minimum.

When both the employee and the spouse are entitled to annuities and the overall minimum rate is higher than the railroad formula rate, the overall minimum amount must be divided between the employee and spouse. The employee receives two-thirds of the total O/M rate. The spouse receives one-third of the total O/M rate.

§ 229.91 Payment of the overall minimum for part of a month.

(a) *Employee annuity payable for part of a month.* If an employee annuity begins after the first day of the month, the O/M amount payable for the partial month is 1/30 of the monthly rate times the number of days in the partial month.

(b) *Spouse annuity payable for part of a month*—(1) *Spouse not included in O/M before beginning date of spouse annuity and O/M applies as of the spouse annuity beginning date.* If a spouse annuity begins after the first day of a month, and the spouse is not includable in the O/M before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date exceeds the amounts payable using the benefit formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30 of the spouse's share of the O/M rate times the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first day of the month, the amount payable to the employee is:

(i) One-thirtieth of the higher of the railroad formula or the O/M rate, without the spouse included, times the number of days in the month before the spouse annuity begins, plus

(ii) One-thirtieth of the employee's share of the O/M rate, with the spouse included, times the number of days in the month beginning with the spouse's annuity beginning date.

(2) *Spouse included in O/M before beginning date of spouse annuity and the O/M continues to apply.* If a spouse annuity begins after the first day of a month, and the spouse is includable in the O/M before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date continues to exceed the amounts payable using the benefit formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30 of the spouse's share of the O/M rate times

the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first of the month, the amount payable to the employee is:

(i) One-thirtieth of the O/M rate, with the spouse included, times the number of days in the month before the spouse annuity begins; plus

(ii) One-thirtieth of the employee's share of the O/M rate, with the spouse included, times the number of days in the month beginning with the spouse's annuity beginning date.

(3) *O/M rate applies before beginning date of spouse annuity and the railroad formula applies as of the spouse annuity beginning date.* If a spouse annuity begins after the first day of a month and the O/M rate applies to the family group, with or without the spouse included, before the beginning date of the spouse annuity, and the O/M rate paid to the family group, including the spouse, as of the spouse annuity beginning date is less than the amounts payable using the formulas under the Railroad Retirement Act, the amount payable to the spouse for the partial month is 1/30 of the spouse's railroad formula rate times the number of days in the month beginning with the spouse's annuity beginning date. In such a case, if the employee annuity is payable from the first day of the month, the amount payable to the employee is:

(i) One-thirtieth of the O/M times the number of days in the month before the spouse annuity begins; plus

(ii) One-thirtieth of the employee's railroad formula rate times the number of days in the month beginning with the spouse's annuity beginning date.

PART 230—MONTHS ANNUITIES NOT PAYABLE BY REASON OF WORK

Sec.

230.1 Statutory provisions.
230.2 Loss of annuity for month in which compensated service is rendered.
230.5 Exception concerning service to a local lodge or division.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: Board Order 60–2, 25 FR 593, Jan. 23, 1960, unless otherwise noted. Redesignated at 47 FR 7656, Feb. 22, 1982.

§ 230.1 Statutory provisions.

No annuity shall be paid with respect to any month in which an individual in receipt of any annuity hereunder shall render compensated service to an employer or to the last person by whom he was employed prior to the date on which the annuity began to accrue. Individuals receiving annuities shall report to the Board immediately all such compensated service. No annuity under paragraph 4 or 5 of subsection (a) of this section shall be paid to an individual with respect to any month in which the individual is under age sixty-five and is paid more than $100 in earnings from employment or self-employment of any form: *Provided,* That for purposes of this paragraph, if a payment in any one calendar month is for accruals in more than one calendar month, such payment shall be deemed to have been paid in each of the months in which accrued to the extent accrued in such month. Any such individual under the age of sixty-five shall report to the Board any such payment of earnings for such employment or self-employment before receipt and acceptance of an annuity for the second month following the month of such payment. A deduction shall be imposed, with respect to any such individual who fails to make such report, in the annuity or annuities otherwise due the individual, in an amount equal to the amount of the annuity for each month in which he is paid such earnings in such employment or self-employment, except that the first deduction imposed pursuant to this sentence shall in no case exceed an amount equal to the amount of the annuity otherwise due for the first month with respect to which the deduction is imposed. If pursuant to the third sentence of this subsection an annuity was not paid to an individual with respect to one or more months in any calendar year, and it is subsequently established that the total amount of such individual's earnings during such year as determined in accordance with that sentence (but exclusive of earnings for services described in the first sentence of this subsection) did not exceed $1,200, the annuity with respect to such month or months, and any deduction imposed by reason of the failure to report earnings for such month or months under the fifth sentence of this subsection, shall then be payable. If the total amount of such individual's earnings during such year (exclusive of earnings for services described in the first sentence of this subsection) is in excess of $1,200, the number of months in such year with respect to which an annuity is not payable by reason of such third and fifth sentences shall not exceed one month for each $100 of such excess, treating

the last $50 or more of such excess as $100; and if the amount of the annuity has changed during such year, any payments of annuity which become payable solely by reason of the limitation contained in this sentence shall be made first with respect to the month or months for which the annuity is larger. (Section 2(d) of the act.)

§ 230.2 Loss of annuity for month in which compensated service is rendered.

If an individual in receipt of an annuity renders compensated service, he shall not be paid an annuity with respect to any month in which such service is rendered to:

(a) An employer;

(b) Any person whether or not an employer by whom he was most recently employed when his annuity begins to accrue;

(c) Any person with whom he held, at the time the annuity begins to accrue, any rights to return to service;

(d) Any person with whom he ceased service in order to have his annuity begin to accrue.

[Board Order 60–2, 25 FR 593, Jan. 23, 1960; 25 FR 1074, Feb. 6, 1960. Redesignated at 47 FR 7656, Feb. 22, 1982]

§ 230.5 Exception concerning service to a local lodge or division.

In determining whether an annuity is subject to the provisions of this part the Board shall disregard any compensated service rendered after December 31, 1936, to a local lodge or division of a railway-labor-organization employer if the compensation for such service is required to be disregarded under the provisions of § 222.3(f) of this chapter.

[Board Order 40–742, 6 FR 298, Jan. 14, 1941. Redesignated at 47 FR 7656, Feb. 22, 1982]

PART 233—REDUCTION IN THE WINDFALL BENEFIT ANNUITY COMPONENT

Sec.

233.1 When reduction must be made.
233.2 Computation of reduction.
233.3 Reduction of retroactive and other similar payments.
233.4 Reconsideration of the reduction computation.

AUTHORITY: Sec. 1122(c), Pub. L. 97–35, 95 Stat. 638 (45 U.S.C. 231f).

SOURCE: 46 FR 50786, Oct. 15, 1981, unless otherwise noted.

§ 233.1 When reduction must be made.

On or before August 31 of each fiscal year, the Board shall, in accordance with this section, determine the amount of the reduction, if any that will have to be made in the following fiscal year in the amount of the windfall benefit components of persons entitled to such benefit components under the Railroad Retirement Act. A reduction must be made where it is determined that the balance in the Dual Benefits Payments Account, comprised of such funds as will be available for the payment of windfall benefits in the following fiscal year including the enacted or estimated appropriation to the Account for the next succeeding fiscal year, disregarding any interest which may be earned by the moneys in the Account during the next fiscal year, is less than the estimate of the amount of the windfall benefits that would be payable under the Railroad Retirement Act during such fiscal year if no reduction were to be applicable. The amount of the windfall benefit as determined by the Board and paid to a person under this section shall constitute full and complete payment of the person's windfall component and there shall be no further liability on the part of the Board, the U.S. Government, or any other person or entity for the amount of any reduction imposed.

§ 233.2 Computation of reduction.

The amount of the reduction to be made in the windfall benefit components of annuities shall be determined in the following manner: the balance in the Dual Benefits Payments Account as determined under § 233.1 shall be divided by the amount of the estimated windfall benefits that would be payable for the fiscal year as determined under § 233.1 to obtain a percentage. This percentage of the unreduced windfall benefit component shall be the amount of that component to which persons are entitled under the Railroad Retirement Act. In no event, however, shall the amount of the windfall benefit exceed the amount that would be payable under the Railroad Retirement Act without regard to this section.

§ 233.3 Reduction of retroactive and other similar payments.

If a person is entitled to a retroactive payment for a month or months in an earlier fiscal year, the reduction factor as imposed with respect to the windfall component of the person's annuity, including that portion attributable to an earlier fiscal year, shall be the reduction factor applicable in the year of payment: *Provided*, *however*, That if the application of the payment year reduction factor would result in a larger payment than would the application of the earlier year reduction factor, the earlier year reduction factor shall be applied. The reduction factor imposed in the case of a replacement payment shall be that reduction factor which was applicable to the original payment. The term ''replacement payment'' means a payment made to a beneficiary to replace a check which was issued to the beneficiary in an earlier month, but which was not negotiated, and ''replacement payment'' also means a payment made to the beneficiary for an earlier month in which his or her annuity was not paid for some reason such as lack of a current address.

§ 233.4 Reconsideration of the reduction computation.

The Board shall periodically, but at least quarterly, examine the determinations and calculations made under §§ 233.1 and 233.2, in view of changes which may occur in the estimates used. If, as a result of this examination, the Board determines that the balance in the Dual Benefits Payments Account will be insufficient to pay benefits from that Account for the balance of the fiscal year at the established rate, the Board shall establish a new rate of reduction to be applied to benefits to be paid for the remaining months so that the balance in the Dual Benefits Payments Account will be sufficient to pay benefits for the remainder of the fiscal year. If, as a result of this examination, the Board finds that the balance in the Account is greater than would be required to pay benefits at the then applicable reduction percentage for the remainder of the fiscal year, the Board may, at its discretion, decrease the reduction percentage with respect to benefits to be paid for the remaining months.

PART 234—LUMP-SUM PAYMENTS

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234.62 Effect of conviction of a felony on entitlement.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 51 FR 3036, Jan. 23, 1986, unless otherwise noted.

Subpart A—General

§ 234.1 Introduction.

This part contains information about the various lump-sum payments payable under sections 6(a)(1) through 6(d)(2) of the 1974 Act.

§ 234.2 Definitions.

As used in this part:

Applicant means the person who signs an application for an annuity or lump-sum for himself, herself or for some other person.

Apply means to sign a form or statement that the Board accepts as an application.

Burial expenses means expenses in connection with the actual burial or other disposition of the remains of the deceased employee.

Eligible means a person meets all the requirements for payment of an annuity or a lump-sum, but has not yet applied.

Employee means any person who is working or has worked for a railroad employer.

Entitled means a person who meets all the requirements for an annuity or a lump-sum, and has applied.

Equitably entitled person means the person whose funds were used to pay the burial expenses of a deceased employee.

Lump-sum means any non-recurring payment due because of an employee's or beneficiary's death.

Person means an individual, partnership, trust estate, association, corporation, government unit, or estate of a deceased individual.

Reimbursable burial expenses means that part of the burial expenses not previously reimbursed by another Federal agency.

Subpart B—Lump-Sum Death Payment

§ 234.10 General.

A lump-sum death payment (LSDP) is payable when an employee with ten or more years of railroad service and a current connection with the railroad industry dies and is not survived by an individual who is eligible for a monthly annuity in the month the employee died. The amount of the LSDP and the priority for payment depend upon when the employee acquired his or her 120th month of railroad service. If the employee acquired the 120th month of railroad service after 1974, a 1974 Act lump-sum death payment is payable to the employee's widow(er). If the employee acquired the 120th month of railroad service before 1975, a 1937 Act lump-sum death payment is payable to the employee's widow(er), the funeral home or the payer of the employee's burial expenses. An application for an LSDP must be filed within two years after the employee's death.

(Approved by the Office of Management and Budget under control number 3220–0031)

[51 FR 3036, Jan. 23, 1986, as amended at 52 FR 11017, Apr. 6, 1987]

§ 234.11 1974 Act lump-sum death payment.

(a) The total amount of the 1974 Act LSDP is payable to the employee's widow(er), if she or he was ''living in the same household'' as the employee at the time of the employee's death. (Refer to § 234.21 for an explanation of ''living in the same household.'')

(b) The amount of the 1974 Act LSDP is equal to three times the amount of the PIA, as determined by section 215 of the Social Security Act, or $255.00, whichever is less.

§ 234.12 1937 Act lump-sum death payment.

(a) The 1937 Act LSDP is payable in the following order and amounts:

(1) The employee's ''living with'' widow(er) is paid the total amount of the LSDP. (Refer to § 234.21 for an explanation of ''living with.'')

(2) A funeral home, which has unpaid expenses, is paid the amount of the unpaid expenses or the total amount of the LSDP, whichever is less.

(3) An equitably entitled person is paid the total amount of the LSDP or a proportionate share of the LSDP, depending upon the amount of burial expenses he or she paid.

(b) The 1937 Act LSDP is equal to ten times the basic amount. (Refer to § 234.20 for an explanation of the computation of the employee's basic amount.)

§ 234.13 Payment to a funeral home.

The 1937 Act LSDP is paid to a funeral home under the following conditions:

(a) A person who has assumed responsibility for all or part of the burial expenses files an application authorizing payment to the funeral home. Usually, the Board considers the person who makes the arrangements with the funeral home or makes a voluntary payment to the funeral home to be the person who has assumed responsibility for the burial expenses.

(b) An official of the funeral home with unpaid expenses files an application on behalf of the funeral home after 90 days have elapsed from the date of the employee's death, if during that 90-day period no one has assumed responsibility for the payment of the burial expenses.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 234.14 Payment to an equitably entitled person.

(a) An equitably entitled person's funds used to pay burial expenses may consist of:

(1) The individual's own money;

(2) Money in a joint account with the employee or another individual;

(3) Money paid to an individual who was named beneficiary to receive the money;

(4) A promissory note; or

(5) Money which several people placed into a pooled fund.

(b) Payment is made to equitably entitled persons in the following order:

(1) The person who paid the funeral home expenses;

(2) The person who paid the grave opening and closing expenses;

(3) The person who provided the burial plot; and

(4) The person who paid any type of expenses not listed in paragraphs (b)(1) through (3) of this section.

§ 234.15 When an employee's estate is entitled.

(a) The employee's estate is considered an equitably entitled person if the funds used to pay burial expenses consisted of:

(1) Money in the employee's single-ownership bank account;

(2) Money paid directly to the funeral home by the employee before death;

(3) Money paid by the employee under a contract, plan, system or general practice where no beneficiary was named to receive the money;

(4) Money found among the employee's effects;

(5) Unpaid salary due the employee by the employee's employer;

(6) Money obtained by selling the employee's real or personal property; or

(7) Money from a trust fund.

(b) If the employee's estate is the equitably entitled person, the Board will pay the LSDP to the legal representative of the employee's estate. When no legal representative of the employee's estate has been or is expected to be appointed, the Board will pay the LSDP according to state statutory procedures applicable when no formal probate or administration occurs.

§ 234.16 When a widow(er) is eligible as an equitably entitled person.

When a widow(er) files for an LSDP and the ''living with'' requirement (described in § 234.21) is not met, the widow(er) could be paid as an equitably entitled person.

§ 234.17 When an equitably entitled person's estate is payable.

When an equitably entitled person dies before negotiating the LSDP

check, that person's share is payable to his or her estate.

§ 234.18 Payment of a deferred lump-sum to a widow(er).

In certain cases, a deferred LSDP may be payable to the employee's widow(er), even if someone may be entitled to a monthly annuity in the month of the employee's death. A deferred LSDP is the difference between the amount of the LSDP and the total of the monthly survivor annuities paid during the 12-month period which begins in the month of the employee's death.

§ 234.19 Effect of payment on future entitlement.

Payment of an LSDP does not affect the entitlement of survivors to monthly annuities at a later date.

§ 234.20 Computation of the employee's 1937 Act LSDP basic amount.

(a) Definition of terms used in this section:

Average monthly remuneration (AMR) means the amount obtained by adding together the creditable compensation and wages earned by the employee after 1936 and before the LSDP closing date and dividing that sum by three times the number of calendar quarters in that period. (Refer to part 211 of this chapter for a definition of creditable compensation and section 209 of the Social Security Act for a definition of creditable wages.)

Closing date means whichever of the following produce the highest AMR:

(1) The first day of the calendar year in which the employee both attained age 65 and was completely insured;

(2) The first day of the calendar year in which the employee died; or

(3) The first day of the calendar year following the year in which the employee died;

(4) However, if paragraphs (a)(1) through (3) of this definition do not occur before January 1, 1975, the closing date is January 1, 1975.

(b) *LSDP basic amount formula.* The basic amount is computed using the following formula:

(1) Determine 52.4% of the AMR up to and including $75.00;

(2) Determine 12.8% of the AMR exceeding $75.00;

(3) Determine 1% of the sum of paragraphs (b)(1) and (2) of this section;

(4) Multiply the result of paragraph (b)(3) of this section by the number of years after 1936 through 1974 in which the employee earned $200 or more;

(5) Add the results of paragraphs (b)(1), (2) and (3) of this section. If the resulting basic amount is less than $18.14, increase it to $18.14.

§ 234.21 Definitions of "living with" and "living in the same household."

(a) *Living with.* A widow(er) is considered ''living with'' the employee at the time of the employee's death, if one of the following conditions applies:

(1) The employee and spouse were members of the same household;

(2) The spouse was receiving regular contributions for support from the employee; or

(3) The employee was under court order to contribute to the spouse's support.

(b)(1) *Living in the same household.* An employee and spouse were ''living in the same household'' if they lived together as a married couple in the same residence. However, an employee and spouse, who were temporarily living apart, will be considered ''living in the same household'' if there was intent to share the same residence had the employee not died. The Board will usually assume that a married couple was living apart temporarily, if the separation was caused by circumstances beyond their control, for example, ill health, financial difficulties, service with the Armed Forces, or confinement in a curative, custodial, or penal institution.

(2) If the employee and spouse were separated solely for medical reasons, the Board will consider them ''living in the same household,'' even if the separation was likely to be permanent.

Subpart C—Annuities Due but Unpaid at Death

§ 234.30 General.

When an applicant or an annuitant dies before being paid any annuities that may be due, the total of those annuities become payable to certain survivors in a lump-sum. Refer to § 234.31

through § 234.34 for information about when and to whom each type of unpaid annuity is payable. An application for an unpaid annuity must be filed within two years after the death of the person originally entitled to the annuity.

(Approved by the Office of Management and Budget under control numbers 3220–0031 and 3220–0032 and 3220–0042)

[51 FR 3036, Jan. 23, 1986, as amended at 52 FR 11017, Apr. 6, 1987]

§ 234.31 Regular employee retirement and supplemental annuities.

A regular employee retirement annuity or a supplemental annuity which is unpaid at the death of the employee is payable in the following order and amounts:

(a) A surviving spouse, who was ''living with'' (see § 234.21) the employee at the time of the employee's death, receives the full amount of the unpaid annuity.

(b) Each person who paid the employee's burial expenses receives a share of the unpaid annuities in the same proportion that he or she paid the burial expenses, but only to the extent that he or she is not reimbursed by the LSDP. If a payer of the employee's burial expenses dies before negotiating his or her check, that payment becomes payable to his or her estate.

(c) Surviving children of the employee receive equal shares.

(d) Surviving grandchildren of the employee receive equal shares.

(e) Surviving parents of the employee each receive equal shares.

(f) Surviving brothers and sisters of the employee receive equal shares. Half blood brothers and sisters share equally with full blood brothers and sisters.

§ 234.32 Spouse or divorced spouse annuities.

A spouse annuity or divorced spouse annuity which is unpaid at the death of the spouse or divorced spouse is paid in the following order and amounts:

(a) The employee receives the full amount.

(b) If the employee died before negotiating the check in payment of the unpaid annuities, the unpaid spouse annuity or divorced spouse annuity is paid in the same order and amounts as described in § 234.31 (b) through (f).

§ 234.33 Survivor annuities.

Any survivor annuity which is unpaid at the death of the survivor is paid in the same order and amounts as described in § 234.31(a) and § 234.31(c) through § 234.31(f).

§ 234.34 When an entitled relative of the employee dies before receiving payment of a due but unpaid annuity.

If a person, who is entitled to unpaid annuities based upon his or her relationship to the employee, dies before negotiating the check in payment of the unpaid annuities, the amount to which he or she was entitled becomes payable to other relatives of the employee in the same degree of relationship. If no relatives in that degree of relationship survive, the amount becomes payable to relatives in the next degree of relationship.

Subpart D—Residual Lump-Sum Payment

§ 234.40 General.

The residual lump-sum (RLS) is the means by which railroad employees and their survivors are guaranteed to receive at least as much in benefits as the employee paid in railroad retirement taxes during the years 1937 through 1974. An RLS payment can be made only if it appears that no other benefits based at least in part on railroad service will be payable under either the Railroad Retirement Act or Social Security Act in the future. The residual is reduced for any retirement benefits that were paid on the basis of the employee's railroad service, and for any survivor benefits based on the employee's earnings already paid by either the Board or the Social Security Administration. A widow(er) or dependent parent can, before attaining age 60, elect to waive future rights to monthly benefits based on the employee's railroad service in order to receive the RLS.

§ 234.41 Persons to whom an RLS is payable.

After the death of an employee, the RLS is payable, in the following order,

to: beneficiaries designated by the employee; surviving relatives of the employee in order provided by law (see § 234.44); or the employee's estate.

§ 234.42 How the employee may designate beneficiaries.

The employee may designate one or more persons as beneficiaries of the RLS on a form available at any Board office. The employee may specify the share that each beneficiary is to receive. Also, the employee may designate alternate beneficiaries in the event that all primary beneficiaries die before the RLS becomes payable.

(Approved by the Office of Mangement and Budget under Control No. 3220–0031)

§ 234.43 Payment to designated beneficiaries.

(a) *How designated beneficiaries are paid.* Primary beneficiaries are paid the RLS to the exclusion of alternate beneficiaries. If a designated beneficiary dies before the date on which the RLS becomes payable, his or her share of the RLS becomes payable to any other designated beneficiaries. If an entitled designated beneficiary dies before negotiating the RLS check, that share is payable to his or her estate.

(b) *Amount designated beneficiaries are paid.* If the employee specified the share that each beneficiary is to receive, payment is made in the proportion specified. Otherwise, if there is more than one designated beneficiary, each is paid an equal share of the RLS.

§ 234.44 Payment to surviving relatives.

(a) *How surviving relatives are paid.* If the employee either did not designate a beneficiary or was not survived by a designated beneficiary, the RLS is payable to surviving relatives of the employee in the following order of relationship to the employee:

(1) Widow(er) who was ''living with'' the employee at the time of the employee's death (see § 234.21 for a definition of ''living with'');

(2) Child;

(3) Grandchild;

(4) Parent;

(5) Brother or sister, including half blood brother or sister.

(b) *Amount surviving relatives are paid.* If more than one relative in an equal degree of relationship survives the employee, each one is paid an equal share of the RLS. If an entitled relative of the employee dies before negotiating the RLS check, that share becomes payable to other surviving relatives of the employee in the same degree of relationship. If no relatives in that degree of relationship survive, relatives in the next degree of relationship are payable.

§ 234.45 Payment to the employee's estate.

(a) *When the employee's estate is paid.* If no designated beneficiaries or relatives survive the employee when the RLS becomes payable, the employee's estate may be paid the RLS. Employees may also designate their estates to receive all or a share of the RLS as beneficiaries.

(b) *How the employee's estate is paid.* If a legal representative of the employee's estate has been appointed and has not been discharged, the Board will pay the RLS to the legal representative. When no legal representative of the employee's estate has been or is expected to be appointed, or the estate of the deceased employee has been closed and reopening is not expected, the Board will pay the RLS according to state statutory procedures applicable when no formal probate or administration occurs.

§ 234.46 Amount of the RLS payable.

The gross RLS amount is equal to certain percentages of the employee's creditable compensation, including military service, as described in § 234.48. (Creditable compensation and military service are discussed in parts 211 and 212 of this chapter, respectively.) The amount of the RLS payable is equal to the gross RLS minus the sum of all retirement benefits that have been paid on the basis of the employee's railroad service and all survivor benefits based on the employee's earnings previously paid by either the Board or the Social Security Administration.

§ 234.47 Election of the RLS by a widow(er) or parent.

(a) An RLS cannot be paid if it appears that there are immediate or future monthly survivor benefits payable to anyone other than a widow(er) or parent. A widow(er) or parent can elect to have the RLS paid in lieu of future monthly benefits based on the employee's railroad earnings under either the Railroad Retirement Act or Social Security Act.

(b) *When an election must be filed.* An election to have the RLS paid must be filed before the widow(er) or parent attains age 60 if he or she would be entitled to benefits under the Railroad Retirement Act, or before the age of eligibility if he or she would be entitled to future benefits under the Social Security Act instead of the Railroad Retirement Act.

(c) *Filing an election.* An election to have the RLS paid must be made on the certification provided by the Board for that purpose, and must contain an irrevocable election to have the RLS paid in lieu of all benefits based on the employee's railroad service to which the widow(er) or parent might otherwise become entitled. Once the RLS check is negotiated, the election cannot be revoked.

§ 234.48 Computation of the gross RLS amount.

The amount of the gross RLS is equal to the percentages of the employee's creditable compensation shown in Table I. However, compensation may only be credited up to the maximum amounts shown in Table II.

(a) *Percentages of the employee's creditable compensation and the periods to which those percentages apply:*

TABLE I

Percent	Period
4	Jan. 1, 1937 through December 1946.
7	Jan. 1, 1947 through December 1958.
7.5	Jan. 1, 1959 through December 1961.
8	Jan. 1, 1962 through December 1965.
8.1	Jan. 1, 1966 through December 1966.
8.65	Jan. 1, 1967 through December 1967.
8.8	Jan. 1, 1968 through December 1968.
9.45	Jan. 1, 1969 through December 1970.
9.85	Jan. 1, 1971 through December 1972.
10.1	Jan. 1, 1973 through September 1973.
5.35	Oct. 1, 1973 through December 1973.
5.45	Jan. 1, 1974 through December 1974.

(b) *Maximum compensation which may be credited per month:*

TABLE II

Compensation per Month	Period
$300	Jan. 1, 1937 through June 1954.
$350	July 1, 1954 through May 1959.
$400	June 1, 1959 through October 1963.
$450	Nov. 1, 1963 through December 1965.
$550	Jan. 1, 1966 through December 1967.
$650	Jan. 1, 1968 through December 1971.
$750	Jan. 1, 1972 through December 1972.
$900	Jan. 1, 1973 through December 1973.
$1,100	Jan. 1, 1974 through December 1974.

Subpart E—Lump-Sum Refund Payment

§ 234.50 General.

Under the 1974 Act, railroad employees with 10 or more years of railroad service, who are not entitled to a vested dual benefit payment, may be eligible for a lump-sum refund payment if they had concurrent railroad and social security earnings within the period 1951 through 1974. The combined earnings from the railroad retirement and social security systems in any of those years must exceed the maximums given in § 234.53. The lump-sum refund is payable to either the employee or the employee's survivors.

§ 234.51 Persons to whom a lump-sum refund payment is payable.

Employees receive their lump-sum refund payment from the Board, without applying for it, at the time their regular annuity is awarded. If an employee dies without receiving payment of a regular annuity, the lump-sum refund payment is payable to the employee's survivors in the same order of priority as shown for the RLS in § 234.44.

§ 234.52 Effect of payment on other benefits.

The lump-sum refund payment is deductible from the RLS; however, it has no effect on the payment of other benefits.

§ 234.53 Computation of the lump-sum refund payment.

(a) *The lump-sum refund payment is calculated as follows:*

(1) Combine the railroad employee's creditable earnings, including military service, under the Social Security Act and Railroad Retirement Act for each of the years 1951 through 1974;

(2) Determine the amount of the employee's creditable earnings in excess of the amounts for each year shown in the chart in paragraph (b) of this section;

(3) Multiply the results of paragraph (a)(2) of this section by the percentage shown in the chart in paragraph (b) of this section; and

(4) Add the results of paragraph (a)(3) of this section. The total is the amount of the lump-sum refund payment.

(b) *Chart for calculation of lump-sum refund payment.*

Year	Amount	Percentage
1951–53	$3,600	1.5
1954–56	4,200	2.0
1957–58	4,200	2.25
1959	4,800	2.5
1960–61	4,800	3.0
1962	4,800	3.125
1963–65	5,400	3.625
1966	6,600	4.2
1967	6,600	4.4
1968	7,800	3.3
1969–70	7,800	4.2
1971	7,800	4.6
1972	9,000	4.6
1973	10,800	4.85
1974	13,200	4.95

Subpart F—Tier II Separation Allowance Lump-Sum Payment

SOURCE: 56 FR 1573, Jan. 16, 1991, unless otherwise noted.

§ 234.55 General.

Under the Railroad Retirement Act certain railroad employees who have received separation or severance payments may be entitled to a lump-sum payment if tier II railroad retirement taxes were deducted from these payments. This part sets forth the conditions for entitlement to the lump-sum payment and explains how the payment is computed.

§ 234.56 Persons to whom a separation allowance lump-sum payment is payable.

(a) An employee who has completed 10 years of service at the time of his or her retirement or death and who has received on or after January 1, 1985, a separation allowance or severance payment (see § 210.11 of this chapter) which would have been used to increase his or her tier II benefit, except for the fact that he or she was neither in an employment relation to one or more employers as defined in part 204 of this chapter nor an employee representative (see part 205 of this chapter), shall be entitled to a lump sum in the amount provided for in § 234.58.

(b) If an employee, otherwise eligible for the lump sum provided for in this section, dies before he or she becomes entitled to a regular annuity or before he or she receives payment of the lump sum, the lump sum is payable to the employee's widow or widower who will not have died before receiving payment. If the employee is not survived by a widow or widower who will not have died before receiving payment, the lump sum is payable to the employee's survivors in the same order of priority as shown for the residual lump-sum (RLS) in § 234.44.

§ 234.57 Effect of payment on other benefits.

The tier II separation allowance lump-sum payment has no effect on the payment of other benefits.

§ 234.58 Computation of the separation allowance lump-sum payment.

The separation allowance lump-sum payment is calculated as follows:

(a) Determine the amount of the compensation due to the receipt of separation or severance pay that could not be considered in the computation of tier II;

(b) Multiply this amount by the rate or rates of tax imposed by section 3201(b) of the Internal Revenue Code of 1954 or 1986 on the compensation (tier II tax); and

(c) The product is the amount of the separation allowance lump-sum payment.

Example: In January of 1988 an employee with 10 years of railroad service relinquished his seniority rights in order to receive a separation allowance of $20,000, thereby severing his employment relation. This was the only creditable railroad compensation earned by the employee in 1988. Both the employer and employee would have paid their share of railroad retirement taxes on this amount. With respect to the employee tier II tax, the tax

rate for 1988 was 4.9% under section 3201(b) of the Internal Revenue Code of 1986. Although the full $20,000 was creditable under the Railroad Retirement Act for tier I benefit computation purposes, only one month's compensation, $2,800, one-twelfth of the annual tier II earnings base of $33,600 for 1988, was creditable for tier II benefit purposes. This is because section 3(i)(4) of the Railroad Retirement Act does not permit crediting of compensation for tier II computation purposes after the employment relation has been severed. Under the lump-sum provision discussed above, the employee in this example would, upon award of his employee annuity, receive a payment of $842.80 ($20,000 minus $2,800, the amount of separation allowance that was creditable, or $17,200 times 4.9%).

Subpart G—Miscellaneous

SOURCE: 51 FR 3036, Jan. 23, 1986. Redesignated at 56 FR 1573, Jan. 16, 1991.

§ 234.60 Escheat.

Any payment under this part which would be payable to any state, political subdivision of a state, the U.S. government or a foreign government because of the lack of a legal heir, shall remain in the Railroad Retirement Account.

§ 234.61 Assignment of interest by an eligible person.

(a) Any person who is eligible to receive a share of a lump-sum payment may assign his or her share to another eligible applicant, provided the share is not more than $500.

(b) If an LSDP or accrued annuity is payable, the request that a share be assigned must be received at a Board office no later than two years after the death of the employee or the originally entitled person.

(Approved by the Office of Management and Budget under control number 3220–0031)

§ 234.62 Effect of conviction of a felony on entitlement.

A person who has been convicted of a felony or an act in the nature of a felony of intentionally causing the employee's death shall not be entitled to any benefits under the Railroad Retirement Act. If a charge of felony is pending against an applicant for a lump-sum payment, the Board will make no payment until the applicant submits proof that the charge has been withdrawn, that no further action will be taken on the charge, or that he or she has been cleared of the charge.

PART 235—PAYMENT OF SOCIAL SECURITY BENEFITS BY THE RAILROAD RETIREMENT BOARD

Sec.

235.1 Basis and purpose.
235.2 Other regulations related to this part.
235.3 Who is paid social security benefits by the Board.
235.4 How the Board pays social security benefits.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 54 FR 5225, Feb. 2, 1989, unless otherwise noted.

§ 235.1 Basis and purpose.

Effective January 1, 1975, the Railroad Retirement Act of 1974 (Act) requires the Railroad Retirement Board (Board) to provide for the payment of monthly social security benefit payments on behalf of the Social Security Administration to certain individuals as described in § 235.3 of this part. However, any such individual who was receiving benefits from the Social Security Administration prior to January 1, 1975, will continue to receive benefits from that agency unless he or she becomes eligible for a different type of social security benefit after that date and files a new application with the Social Security Administration for that benefit. Benefits under the new entitlement will be paid by the Board. The Act provides an offset in the railroad retirement benefits of individuals who are also eligible for social security benefits. Because the Board is required to make this offset, the payment of social security benefits by the Board is authorized for the purpose of convenience in the administration of the Act.

§ 235.2 Other regulations related to this part.

This part is related to a number of other parts in this chapter:

(a) Part 216 describes when a person is eligible for an annuity under the Railroad Retirement Act.

(b) Part 222 defines family relationships (for example, who is the wife or widow of an employee) for use when it

is necessary to establish such a relationship in order to receive a benefit under the Railroad Retirement Act.

§ 235.3 Who is paid social security benefits by the Board.

The following individuals, if entitled to social security benefits, are paid such benefits by the Board:

(a) A railroad employee who has been credited with at least 120 months of railroad service;

(b) A wife or husband of a railroad employee who has been credited with at least 120 months of railroad service;

(c) A divorced wife or husband of a railroad employee who has been credited with at least 120 months of railroad service, but only if the divorced wife or husband is claiming social security benefits based upon the railroad employee's social security wages;

(d) A survivor of a railroad employee, including a surviving divorced spouse, remarried widow(er), surviving divorced mother or father, who is entitled, or upon application would be entitled, to an annuity under the Railroad Retirement Act;

(e) Any other person entitled to benefits under title II of the Social Security Act based on the social security wages of a railroad employee who has been credited with at least 120 months of railroad service, except survivors of a railroad employee when the Social Security Administration has jurisdiction for survivor benefits. See part 221 of this title.

§ 235.4 How the Board pays social security benefits.

(a) When an individual described in § 235.3 of this part is determined by the Social Security Administration to be entitled to social security benefits, the Social Security Administration certifies such benefits to the Board for payment by the Board. Once social security entitlement is certified to the Board, the Board then certifies the amount of the social security benefit to the Department of the Treasury for payment and makes any necessary adjustments in the individual's railroad retirement benefit.

(b) The Board has no authority with respect to the adjudication of the benefit to be paid under the Social Security Act. Entitlement to and the computation of such benefits is a matter solely within the jurisdiction of the Social Security Administration.

PARTS 236–238 [RESERVED]

PART 240 [RESERVED]

PART 243—TRANSFER, ASSIGNMENT, OR WAIVER OF PAYMENTS

Sec.

243.1 Prohibition against garnishment.
243.2 Legal process for the enforcement of child support and alimony obligations.
243.3 Payments pursuant to court decree or court-approved property settlement.
243.4 Taxation of benefits.
243.5 Assignment of a portion of an annuity paid under the social security overall minimum provision.
243.6 Waiver of annuity payments.

AUTHORITY: 45 U.S.C. 231f(b)(5).

SOURCE: 53 FR 35806, Sept. 15, 1988, unless otherwise noted.

§ 243.1 Prohibition against garnishment.

Except as hereinafter provided in this part, no benefits paid under the Railroad Retirement Act are assignable or subject to any tax or to garnishment, attachment, or other legal process (including any order issued by any court in connection with a bankruptcy proceeding), nor shall any payment be anticipated.

§ 243.2 Legal process for the enforcement of child support and alimony obligations.

Benefits paid by the Board are subject to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments, as provided in part 350 of this chapter.

§ 243.3 Payments pursuant to court decree or court-approved property settlement.

Certain annuity components are subject to division pursuant to a court decree or to a court-approved property settlement incident to any such decree, as provided in part 295 of this chapter.

§ 243.4 Taxation of benefits.

(a) Annuities paid by the Board are subject to Federal income tax in accord with the Internal Revenue Code. The annuity portion equivalent to the amount of the benefit that the person would have actually received under the Social Security Act if railroad service had been creditable under that Act is treated for Federal income tax purposes the same way as a social security benefit. Annuity payments computed under the social security overall minimum provision contained in section 3(f)(3) of the Railroad Retirement Act (see § 243.5 of this part) are also treated as social security benefits for Federal income tax purposes. Railroad retirement annuity amounts exceeding social security equivalent payments, vested dual benefits, and supplemental annuities are taxed in the same manner as benefits provided under an employer plan which meets the requirements of section 401(a) of the Internal Revenue Code.

(b) Pursuant to section 14 of the Railroad Retirement Act, no annuity or supplemental annuity, in whole or in part, is subject to any tax by any state or any political subdivision thereof.

§ 243.5 Assignment of a portion of an annuity paid under the social security overall minimum provision.

Section 3(f)(3) of the Railroad Retirement Act, the social security overall minimum provision, guarantees that an annuitant will receive, in combined benefits under the Railroad Retirement and Social Security Acts, not less than the amount which would have been paid to the employee and to members of his or her family under the Social Security Act if the employee's railroad service had been creditable under that Act. An annuitant whose annuity is computed under that provision may assign all or any portion of that annuity to any of the members of his or her family who are or who could be included in the computation of the annuity. Any assignment issued pursuant to this section will terminate:

(a) When revoked by the annuitant by notification to the Board; or

(b) When the annuity is no longer computed under the social security overall minimum provision.

§ 243.6 Waiver of annuity payments.

(a) Any individual who has been awarded an annuity under the Railroad Retirement Act shall have the right to waive such annuity in whole or in part by filing with the Board a statement to that effect signed by him or her.

(b) Such a waiver shall be effective as of the date specified in the waiver statement, except that if an annuity has been awarded, a waiver shall not be effective before the first day of the month after the month in which the waiver form is received at an office of the Board and shall not be effective as to any annuity payment which has already been made or which cannot be prevented.

(c) For the period during which a waiver is in effect, no payment of the amount of the annuity waived can ever be made to any person. A waiver of an annuity shall not, however, have any effect on the amount of a spouse's annuity otherwise payable or on a lump sum under section 6(c) of the Act otherwise due, nor shall it serve to make an individual eligible for a lump-sum death benefit under section 6(b) of the Act or any insurance benefit under the Social Security Act on the basis of the wages of the same deceased employee.

(d) A waiver once made shall continue in effect until the annuitant requests in writing that it be terminated.

PART 250 [RESERVED]

PART 255—RECOVERY OF OVERPAYMENTS

Sec.

255.1 Introduction.
255.2 Overpayments.
255.3 When overpayments are to be recovered.
255.4 Persons from whom overpayments may be recovered.
255.5 Recovery by cash payment.
255.6 Recovery by setoff.
255.7 Recovery by deduction in computation of death benefit.
255.8 Recovery by adjustment in connection with subsequent payments.
255.9 Individual enrolled under supplementary medical insurance plan.
255.10 Waiver of recovery.
255.11 Fault.
255.12 When recovery is contrary to the purpose of the Railroad Retirement Act.

255.13 When recovery is against equity or good conscience.
255.14 Waiver not available when recovery can be made from accrual of social security benefits.
255.15 Waiver to an estate.
255.16 Administrative relief from recovery.
255.17 Recovery of overpayments from a representative payee.
255.18 Compromise of overpayments.
255.19 Suspension or termination of the collection of overpayments.

AUTHORITY: 45 U.S.C. 231f(b)(5); 45 U.S.C. 231i.

SOURCE: 62 FR 64163, Dec. 4, 1997, unless otherwise noted.

§ 255.1 Introduction.

Section 10 of the Railroad Retirement Act provides for the recovery of an overpayment of benefits to an individual. This part explains when an overpayment must be recovered, from whom an overpayment may be recovered, and when recovery of the overpayment may be waived or administrative relief from recovery granted, and circumstances under which the overpayment may be compromised, or circumstances under which recovery of the overpayment may be suspended or terminated.

§ 255.2 Overpayments.

An overpayment, within the meaning of this part, is made in any case in which an individual receives a payment under the Railroad Retirement Act, all or part of which payment he or she is not entitled to receive.

§ 255.3 When overpayments are to be recovered.

Overpayments shall be recovered in all cases except those in which recovery is waived under § 255.10 of this part or administrative relief from recovery is granted under § 255.16 of this part, or where the overpayment is compromised or recovery is terminated or suspended under §§ 255.18 or 255.19 of this part.

§ 255.4 Persons from whom overpayments may be recovered.

(a) *Overpaid individual.* The Board may recover an overpayment from the individual to whom the overpayment has been made by any method permitted by this part, or by the Federal Claims Collection Standards (4 CFR chapter 2) (Example 1 of this section). If the overpaid individual dies before recovery is completed, then recovery may be effected by recovery from the estate or the heirs of such individual.

(b) *Other than overpaid individual.* The Board may recover an overpayment from a person other than the overpaid individual if such person is receiving benefits based upon the same record of compensation as the overpaid individual under a statute administered by the Board. In such a case, the Board will ordinarily recover the overpayment by setoff against such benefits as are provided for in § 255.6 of this part (Example 2 of this section). However, the Board may ask for a cash refund of the overpayment.

(c) *Individual not in the same household.* Recovery under paragraph (b) of this section may be made from an individual who was not living in the same household, as defined in part 216 of this chapter, as the overpaid individual at the time of the overpayment, if the individual from whom recovery is to be made either was aware that benefits were being paid incorrectly or benefitted from the overpayment. (Example 3 of this section).

(d) *Examples.* This section may be illustrated by the following examples:

Example (1). An employee receiving a disability annuity returns to work without notifying the Board. The Board discovers that the employee is working and determines that the employee has recovered from his disability and has been overpaid. The Board requests that the employee repay the overpayment by cash refund either in one lump sum or in installment payments. If the employee refuses, the Board may refer the debt to a collection agency or the Department of Justice for civil suit or may collect the debt in any other manner permitted by law.

Example (2). The employee in Example 1 agrees to refund the overpayment by cash installment payments. However, the employee dies before repaying the total amount of the overpayment. At his death the employee's widow, who was living with the employee at the time the overpayment was incurred, becomes entitled to a widow's annuity. The Board may recover the remainder of the overpayment from any benefits due the widow.

Example (3). C, a child of a deceased employee by his first marriage, is receiving a disability annuity on the employee's record of compensation. W, the employee's second wife, is receiving a widow's annuity on the

employee's record of compensation. C lives with his mother, the employee's first wife. C marries without notifying the Board. Marriage terminates a child's annuity. W is not aware of C's marriage. Upon discovery of C's marriage, the Board demands that C refund the overpaid annuities; C refuses. Even though W is receiving an annuity based upon the same record of compensation as that of C, the Board will not recover the overpayment from W because she is not in the same household as C, was not aware of the incorrect benefits paid, and did not benefit from them.

§ 255.5 Recovery by cash payment.

The Board shall have the right to require that an overpayment to an individual be immediately and fully repaid in cash by that individual. However, if the Board determines that the individual is financially unable to pay the amount of the indebtedness in a lump sum, payment may be accepted in regular installments in accordance with the Federal Claims Collection Standards, found in 4 CFR chapter 2. These standards provide that whenever possible installment payments should be sufficient in amounts and frequency to liquidate the debt in not more than 3 years.

§ 255.6 Recovery by setoff.

An overpayment may be recovered by setoff from any subsequent payment determined to be payable under any statute administered by the Board to the individual who received the overpayment. An overpayment may be recovered from someone other than the overpaid individual by setoff from a subsequent payment determined to be payable to that other individual on the basis of the same record of compensation as that of the overpaid individual.

§ 255.7 Recovery by deduction in computation of death benefit.

In computing the residual lump sum provided for in part 234, subpart D, of this chapter, the Board shall include in the benefits to be deducted from the applicable percentages of the aggregate compensation provided for in that part all overpayments, whether waived under § 255.10 of this part or otherwise not recovered, that were paid to the employee or to his or her spouse or to his or her survivors with respect to the employee's employment.

§ 255.8 Recovery by adjustment in connection with subsequent payments.

(a) Recovery of an overpayment may be made by permanently reducing the amount of any annuity payable to the individual or individuals from whom recovery is sought. This method of recovery is called an actuarial adjustment of the annuity. The Board cannot require any individual to take an actuarial adjustment in order to recover an overpayment nor is an actuarial adjustment available as a matter of right. An actuarial adjustment becomes effective and the debt is considered recovered when, in the case of an individual paid by electronic funds transfer, the first annuity payment reflecting the annuity rate after actuarial adjustment is deposited to the account of the overpaid individual, or, in the case of an individual paid by check, the first annuity check reflecting the annuity rate after actuarial adjustment is negotiated.

Example. An annuitant agrees to recovery of a $5,000 overpayment by actuarial adjustment. However, the annuitant dies before negotiating the first annuity check reflecting the actuarially-reduced rate. The $5,000 is not considered recovered. If the annuitant had negotiated the check before he died, the $5,000 would be considered fully recovered.

(b) In calculating any adjustment under this section, beginning with the first day of January after the tables and long-term or ultimate interest rate go into effect under section 15(g) of the Railroad Retirement Act (the triennial evaluation), the Board shall use those tables and long-term or ultimate interest rate.

[63 FR 29548, June 1, 1998]

§ 255.9 Individual enrolled under supplementary medical insurance plan.

Where recovery of the overpayment is by setoff as provided for in § 255.6 of this part, and where recovery of the overpayment by such means will be accomplished within a period of 5 months, and the individual from whom recovery is sought is an enrollee under Part B of Title XVIII of the Social Security Act (Supplementary Medical Insurance Benefits for the Aged and Disabled), an amount of such individual's monthly benefit which is equal to his

or her obligation for supplementary medical insurance premiums will be applied toward payment of such premiums, and the balance of the monthly benefit will be applied toward recovery of the overpayment.

§ 255.10 Waiver of recovery.

There shall be no recovery from any person in any case where more than the correct amount of annuities or other benefits has been paid to an individual or where payment has been made to an individual not entitled thereto if in the judgment of the Board:

(a) The overpaid individual is without fault, and

(b) Recovery would be contrary to the purpose of the Railroad Retirement Act or would be against equity or good conscience.

§ 255.11 Fault.

(a) Before recovery of an overpayment may be waived, it must be determined that the overpaid individual was without fault in causing the overpayment. If recovery is sought from other than the overpaid individual but the overpaid individual was not without fault, then waiver is not available. However, see § 255.16 of this part for provisions as to when administrative relief from recovery may be granted in such circumstances.

(b) Fault means a defect of judgment or conduct arising from inattention or bad faith. Judgment or conduct is defective when it deviates from a standard of reasonable care taken to comply with the entitlement provisions of this chapter. Conduct includes both action and inaction. Unlike fraud, fault does not require a deliberate intent to deceive.

(c) Whether an individual is at fault in causing an overpayment generally depends on all circumstances surrounding the overpayment. Among the factors the Board will consider are: the ability of the overpaid individual to understand the reporting requirements of the Railroad Retirement Act or to realize that he or she is being overpaid (*e.g.*, age, education, comprehension, physical and mental condition); the particular cause of non-entitlement to benefits; and the number of instances in which the individual may have made erroneous statements.

(d)(1) Circumstances in which the Board will find an individual at fault include but are not limited to:

(i) Failure to furnish to the Railroad Retirement Board information which the individual knew or should have known to be material;

(ii) An incorrect statement made by the individual which he or she knew or should have known was incorrect (including furnishing an opinion or conclusion when asked for facts); and

(iii) Failure to return a payment which the individual knew or should have known was incorrect.

(2) Where any of the circumstances listed in paragraph (d)(1) are found to have occurred, the individual shall be presumed to be not without fault. This presumption may be rebutted, but the burden of presenting evidence to rebut the presumption is on the individual.

(3) For purposes of paragraph (d)(1)(i), furnishing information to the Social Security Administration or any other agency shall not be considered to constitute furnishing information to the Railroad Retirement Board.

(4) For purposes of this section, an error on the part of the agency shall not extinguish fault on the part of the individual.

(e) Circumstances in which the Board will find an individual not at fault include but are not limited to:

(1) The overpayment is the result of Board error of which the overpaid individual was not aware and could not reasonably have been expected to be aware (Example 1 of this section).

(2) The overpayment is the result of an adjustment to the overpaid individual's annuity because of entitlement of another individual to an annuity on the same record of compensation as that of the overpaid individual (Example 2 of this section).

(3) The overpayment is the result of the Board's continuing to pay an individual after he or she has notified the Board of an event which caused or should have caused a reduction in his or her benefit; provided that continued payment of the unreduced benefit led the individual to believe in good faith that he or she was entitled to the payments subsequently received.

(f) The application of this section may be illustrated by the following examples:

Example (1). The Board makes a mathematical error in the computation of an employee's annuity, thus giving the employee a higher rate than he or she is entitled to but which is sufficiently close to the estimated rate given the employee at the time he or she applied for the annuity that the employee believed, in good faith, that the amount was correct. The employee is not at fault in causing the overpayment in this case. The overpayment may be waived if the requirements of § 255.12 or § 255.13 of this part are met.

Example (2). The widow and four minor children of a railroad employee are receiving benefits from the Board under the family maximum. Another minor child not living in the same household as the above individuals is also determined to be the child of the deceased employee. The widow was not aware of the existence of this child. An award of benefits to this child causes a reduction in benefits to the other individuals under the family maximum benefit provision of the Social Security Act. Because of normal administrative delay this reduction does not take place for a period of 2 months after its effective date. The widow and her children are without fault with respect to this overpayment. The overpayment may be waived if the requirements of § 255.12 or § 255.13 of this part are met.

§ 255.12 When recovery is contrary to the purpose of the Railroad Retirement Act.

(a) The purpose of the Railroad Retirement Act is to pay retirement and survivor annuities and other benefits to eligible beneficiaries. It is contrary to the purpose of the Act for an overpayment to be recovered from income and resources which the individual requires to meet ordinary and necessary living expenses. If either income or resources, or a combination thereof, are sufficient to meet such expenses, recovery of an overpayment is not contrary to the purpose of the Act.

(b) For purposes of this section, income includes any funds which may reasonably be considered available for the individual's use, regardless of source, including inheritance prospects. Income to the individual's spouse or dependents is available to the individual if the spouse or dependent lived with the individual at the time waiver is considered. Types of income include but are not limited to:

(1) Government benefits, such as Black Lung, Social Security, Workers' Compensation, and Unemployment Compensation benefits;

(2) Wages and self-employment income;

(3) Regular incoming payments, such as rent or pensions; and

(4) Investment income.

(c) For purposes of this section, resources may include:

(1) Liquid assets, such as cash on hand, the value of stocks, bonds, savings accounts, mutual funds and the like;

(2) Non-liquid assets (except an individual's primary residence) at their fair market value; and

(3) Accumulated, unpaid Federal benefits.

(4) For purposes of paragraphs (c)(1) and (2) of this section, assets concealed or improperly transferred on and after the date of notification of the overpayment, other than cash expended to meet ordinary and necessary living expenses, shall be included.

(d) Whether an individual has sufficient income and resources to meet ordinary and necessary living expenses depends not only on the amount of his or her income and resources, but also on whether the expenses are ordinary and necessary. While the level of expenses which is ordinary and necessary may vary among individuals, it must be held at a level reasonable for an individual who is living on a fixed income. The Board will consider the discretionary nature of an expense in determining whether it is reasonable. Ordinary and necessary living expenses include:

(1) Fixed living expenses such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (*e.g.*, life, accident, and health insurance), taxes, installment payments, etc.;

(2) Medical, hospital, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Miscellaneous expenses (*e.g.*, newspapers, haircuts).

(e) Where recovery of the full amount of an overpayment would be made from income and resources required to meet ordinary and necessary living expenses, but recovery of a lesser amount would leave income or resources sufficient to meet such expenses, recovery of the lesser amount is not contrary to the purpose of the Act.

(f) This section may be illustrated by the following examples:

Example (1). A remarried widow, W, is overpaid $6000 due to receipt of benefits on the wage records of both her late husbands. It has been determined that she is without fault. Her financial disclosure statement reveals monthly income greater than monthly expenses, and assets of $12,000, $10,000 of which is in cash. She claims to be saving these funds for future medical expenses, because she has a progressive disease. While it is not necessarily contrary to the purposes of the Act to recover the overpayment in these circumstances, the legitimate medical expenses associated with the disease must be considered.

Example (2). A disability annuitant, D, is overpaid $33,000 because of simultaneous entitlement to workers' compensation payments. He is determined to be without fault. He claims he has assumed financial responsibility for his adult child and her children. A claimed expense for which the annuitant has no legal obligation to pay does not make recovery contrary to the purposes of the Act.

§ 255.13 When recovery is against equity or good conscience.

(a) Recovery is considered to be against equity or good conscience if a person, in reliance on payments made to him or her or on notice that payment would be made, relinquished a significant and valuable right (Example 1 of this section) or changed his or her position to his or her substantial detriment (Example 2 of this section).

(b) An individual's ability to repay an overpayment is not material to a finding that recovery would be against equity or good conscience but is relevant with respect to the credibility of a claim of detrimental reliance under paragraph (a) of this section.

(c) This section may be illustrated by the following examples:

Example (1). After being informed by the Board that he had been credited with sufficient years of railroad service to retire at age 60, an employee quit his railroad job and applied for benefits under the Railroad Retirement Act. He receives benefits for six months when it is discovered that he had insufficient railroad service to retire at age 60 and was not entitled to the benefits he received. His annuity was terminated. Because the employee gave up his seniority rights when he quit his railroad job, he cannot get his job back. It is determined that the employee was not at fault in causing the overpayments. In this situation recovery of the overpayment would be against equity or good conscience because the overpaid individual gave up a valuable right.

Example (2). A widow, having been awarded annuities for herself and her daughter, entered her daughter in a private school. The widow did not have substantial assets and her income, apart from the annuities she received in the amounts payable, would not have been sufficient for her to have undertaken the obligation to send her daughter to private school. In order to pay for the schooling she took out a loan and used the monthly annuities to pay interest and principal on the loan. After the widow and her daughter had received payments for almost a year, the deceased employee was found not to have been insured under the Railroad Retirement Act. Therefore, all payments to the widow and child were erroneous and the annuities were terminated. It is determined that the widow was not at fault in causing the overpayment. Having incurred a financial obligation (the school loan) toward which the benefits had been applied, the widow was in a worse position financially than if she and her daughter had never been entitled to benefits. In this situation, the recovery of the overpayment would be against equity or good conscience.

§ 255.14 Waiver not available when recovery can be made from accrual of social security benefits.

Where the overpayment is the result of a reduction of benefits payable under the Railroad Retirement Act due to the overpaid individual's entitlement to social security benefits and recovery of such overpayment may be made by offset against an accrual of social security benefits, it shall not be considered to be against equity or good conscience or contrary to the purpose of the Railroad Retirement Act to recover the overpayment by offset against the accrual. Consequently, in such a case recovery of an overpayment is not subject to waiver consideration.

§ 255.15 Waiver to an estate.

It shall never be considered contrary to the purpose of the Railroad Retirement Act to recover an overpayment

from the estate of an overpaid individual.

§ 255.16 Administrative relief from recovery.

(a) Where the Board seeks to recover an overpayment from someone other than the overpaid individual, as provided for in § 255.4 of this part, and where waiver of recovery, as provided for in § 255.10 of this part, is not available because the overpaid individual was at fault as defined in § 255.11 of this part, the Board may forego recovery of the overpayment where the individual from whom recovery is sought was not at fault in causing the overpayment and where recovery is contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part.

(b) Application of administrative relief from recovery with respect to a given person from whom recovery may be made shall have no effect on the authority of the Board to recover the overpayment from anyone else from whom recovery may be sought.

(c) This section may be illustrated by the following examples:

Example (1): An employee, through his own fault, causes an overpayment in his annuity. The employee dies before the overpayment can be recovered from him and he leaves no estate. A widow's annuity is payable on the employee's compensation record. The widow was not at fault in causing the overpayment. The Board may recover the remainder of the overpayment by setoff against the widow's annuity. However, it may forego recovery under this section if such recovery would be contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part. Since this is not a waiver of the overpayment, the Board is free to recover the overpayment from the widow at a later date, for example, if an accrual of benefits should become payable, or if it determines that such recovery would not be against the purpose of the Railroad Retirement Act.

Example (2): A representative payee for a retarded child, through her own fault, causes an overpayment in the child's annuity. The overpaid amounts were used for the benefit of the child. The representative payee dies before the overpayment can be recovered from her and she leaves no estate. The Board may not waive the remainder of the overpayment with respect to the child since for purposes of waiver the representative payee is considered the overpaid individual (see § 255.17 of this part) and the overpaid individual was at fault. However, if the child was not at fault in causing the overpayment and recovery would be contrary to the purpose of the Railroad Retirement Act as defined in § 255.12 of this part, then the Board may forego recovery of the overpayment from the child's annuity under this section.

§ 255.17 Recovery of overpayments from a representative payee.

(a) *Joint liability.* In general, if an overpayment is made to an individual receiving benefits as a representative payee (see part 266 of this chapter) the Board may recover the overpayment from either the representative payee or the beneficiary, or both. If the beneficiary is currently receiving benefits, either in his or her own right or through a representative payee, the Board will generally propose to recover the overpayment by setoff against those benefits as provided for in § 255.6 of this part. If the beneficiary is not currently receiving benefits but the representative payee is receiving benefits, then the Board will generally propose to recover the overpayment by setoff against those benefits.

(b) *Waiver of overpayments.* For purposes of § 255.10 of this part (Waiver of recovery), if it is determined that the representative payee was at fault in causing the overpayment there may be no waiver of the overpayment either as to the representative payee or the beneficiary. However, if the beneficiary was not at fault in causing the overpayment he or she may be eligible for administrative relief from recovery under § 255.16 of this part.

(c) This section may be illustrated by the following examples:

Example (1). M is receiving a child's annuity as a representative payee for her disabled son, S. With M's knowledge S marries. Although both M and S know that marriage terminates the child's annuity, neither of them informs the Board of this event. Both M and S are liable for any overpayment caused. Waiver is not available since M would be considered at fault in causing the overpayment. Administrative relief from recovery is not available to S since he would also be considered at fault.

Example (2). R is a representative payee for B, who resides in a skilled-care facility. R is found to be at fault in causing an overpayment of benefits to B. The Board may recover the overpayment from either R or B. Waiver is not available because R was at fault in causing the overpayment. However,

if B was not at fault in causing the overpayment he or she may be entitled to administrative relief from recovery under §255.16 of this part.

§ 255.18 Compromise of overpayments.

(a) This section sets forth the principal standards which the Board applies in exercising its authority under 31 U.S.C. 3711 to compromise an overpayment. In addition, the Board may compromise an overpayment under the Federal Claims Collection Standards set forth in 4 CFR part 103.

(b) An overpayment may be compromised only if it is in the best interest of the agency. Circumstances and factors to be considered are:

(1) The overpayment cannot be collected because of the overpaid individual's inability to pay the full amount of the overpayment within a reasonable time;

(2) The overpaid individual refuses to pay the overpayment in full and it appears that enforced collection procedures will take an inordinate amount of time or that the cost of collecting does not justify the enforced collection of the full amount; or

(3) There is doubt that the Board could prove its case in court for the full amount claimed because of a bona fide dispute as to the facts or because of the legal issues involved.

§ 255.19 Suspension or termination of the collection of overpayments.

This section sets forth the principal standards which the Board applies in approving the suspension or termination of the collection of an overpayment. In addition the Board may suspend or terminate collection under the Federal Claims Collection Standards set forth in 4 CFR part 104.

(a) Collection action on a Board claim may be suspended temporarily when the debtor cannot be located and there is reason to believe future collection action may be productive or collection may be effected by offset in the near future.

(b) Collection action may be terminated when:

(1) The debtor is unable to make any substantial payment;

(2) The debtor cannot be located and offset is too remote to justify retention of the claim;

(3) The cost of collection action will exceed the amount recoverable; or

(4) The claim is legally without merit or cannot be substantiated by the evidence.

PART 258—HEARINGS BEFORE THE BOARD OR DESIGNATED EXAMINERS

Sec.

258.1 Hearings.
258.2 Witnesses.
258.3 Application for witnesses.
258.4 Service of subpoenas.
258.5 Exhibits.
258.6 Procedure when examiner appointed.
258.7 Board decisions and opinions and dissenting opinions.

AUTHORITY: Sec. 10, 50 Stat. 314, as amended; 45 U.S.C. 228j, unless otherwise noted.

SOURCE: 43 FR 56888, Dec. 5, 1978, unless otherwise noted.

§ 258.1 Hearings.

(a) To such extent as may be necessary to determine (1) the employee status of any individual or group of individuals, (2) the employer status of any person, and (3) any other matter arising out of or necessary for the administration of the Railroad Unemployment Insurance Act and the Railroad Retirement Acts of 1935, 1937, and 1974, other than those matters specifically provided for in parts 260 and 320 of this chapter, the Board may itself or through one of its members or a designated examiner, conduct hearings, require and compel the attendance of witnesses and the production of records and documents, administer oaths, take testimony, make all pertinent investigations and findings of fact, and render decisions upon such findings.

(b) Where the Board determines that an oral hearing is necessary to the determination of a matter before it, the Board shall notify all parties to the proceeding that a hearing will be conducted, and, if the hearing is to be before a single Board member or a designated examiner, the notice shall identify the member or examiner authorized to conduct the hearing. The Board or the person authorized to conduct the hearing shall fix a time and place for the holding of the hearing and shall notify all parties thereof.

§ 258.2 Witnesses.

(a) In any hearing held pursuant to the provisions of this part, witnesses may be compelled to appear, give testimony, and produce records and documents.

(b) Designation by the Board of any person as an examiner to preside at and conduct such hearings shall constitute a delegation of authority to such examiner to require and compel the attendance of witnesses and the production of records and documents, to administer oaths, and to take testimony.

§ 258.3 Application for witnesses.

(a) Any person or persons conducting a hearing pursuant to the provisions of this part or part 260 of this chapter may, upon such person's or persons' own motion or upon application of any party to such hearing, issue a subpoena for a witness or witnesses. An application for a subpoena shall be by affidavit filed with the person or persons conducting the hearing within such period of time as will permit service and return of a subpoena prior to the date set for the hearing at which the witness is to appear, but in no case shall such application be filed later than 10 days prior to the date of hearing. The application shall set forth:

(1) The name and address of the witness;

(2) The title of the matter to be heard, i.e., names of parties;

(3) The issue to which the testimony of the witness will be directed;

(4) The substance of the testimony which such witness is expected to give or the facts to which such witness will testify; and

(5) The specific books, papers or documents which are requested, if a subpoena duces tecum is applied for.

(b) In addition to the above, the party filing such application shall, at the time of filing, deposit therewith a sum of money sufficient to cover the fees and transportation allowance of the witness, or, in lieu thereof, shall state in the application that satisfactory arrangements have been made with the witness for the direct payment of his or her fees and transportation allowance and any other allowable expense.

§ 258.4 Service of subpoenas.

Service of subpoenas issued under § 258.3 may be made by any individual designated by the Board. Such individual shall deliver a copy of the subpoena to the person or persons named therein, and shall at that time tender to that person or persons the fees for one day's attendance and the transportation allowance authorized by law; *Provided, however*, That if the witness or witnesses be summoned to appear upon motion of the person or persons designated to conduct the hearing, no fees or transportation allowance need be tendered. Fees and transportation allowances shall be in the same amount as is allowed to witnesses in the courts of the United States. The person serving the subpoena shall make certification of the manner and time of service on the original subpoena and shall file such original subpoena with the person or persons by whom it was issued.

§ 258.5 Exhibits.

Copies of all exhibits admitted in evidence at any hearing held pursuant to the provisions of this part shall be furnished by the party offering the same to all other parties participating in the proceedings.

§ 258.6 Procedure when examiner appointed.

(a) Where an examiner has been designated by the Board under this part to conduct a hearing with respect to a matter before it, the examiner shall preside at the hearing and shall cause all testimony to be recorded. The examiner shall, as soon as practicable following the conclusion of the hearing, mail to each party at the address stated in his or her appearance a free transcript of the record of the proceedings had before the examiner. Thereafter, the examiner shall give all parties participating in the hearing the opportunity to present argument upon both law and facts. Upon conclusion of the proceedings before him or her, the examiner shall prepare a report which, together with the record of the proceedings before him or her, shall be submitted to the Board. The report shall set forth the examiner's findings

of fact, conclusions of law, and recommendations as to decision. The report may also contain such discussion of the question raised, both legal and factual, as the examiner may desire to present to the Board. A copy of the examiner's report shall be served by the examiner upon each party participating in the hearing by mailing such copy to each such party at the address stated in his or her appearance. Each party shall, within 30 days after the date of mailing to him or her of the examiner's report, file with the Board and serve upon other parties by mailing to their addresses as stated in their appearances such exceptions in writing as he or she desires to make to the examiner's findings of fact and conclusions of law. Each exception shall specifically designate the particular findings of fact or conclusions of law to which objection is taken, and shall set forth in detail the grounds for the objection. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered by the Board. Exceptions to findings of fact shall make specific reference by page numbers to those portions of the record upon which reliance is placed.

(b) Each party shall have 10 days after receipt of exceptions taken by other parties in which to file with the Board replies to those exceptions. Replies to exceptions to findings of fact shall make specific reference by page number to those portions of the record upon which reliance is placed.

(c) The Board may, upon the application of a party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The Board will render its decision upon the record, the examiner's report, and such exceptions and replies thereto as are made.

(d) The examiner's report shall be advisory only and the Board may, in any case, exercise its right to reject or adopt the examiner's report in whole or in part or adopt such report with modifications. Findings of fact to which no exceptions are taken will, subject only to the power of the Board upon its own consideration to reject or modify, be presumed to be correct.

(e) The decision of the Board shall be communicated to the parties participating in the hearing within 30 days of the date upon which the decision of the Board is entered upon its records.

§ 258.7 Board decisions and opinions and dissenting opinions.

The following shall apply to all decisions of the Board except decisions relating to matters of internal administration:

A decision made by at least two members of the Board shall constitute the decision of the Board. The decision of the Board shall be stated in a written opinion filed in the record of the proceedings. A dissenting opinion may be stated by a member of the Board who disagrees with the decision of the Board and any such dissenting opinion shall also be filed in the record of the proceedings.

PART 259—INITIAL DETERMINATIONS AND APPEALS FROM INITIAL DETERMINATIONS WITH RESPECT TO EMPLOYER STATUS AND EMPLOYEE STATUS

Sec.

259.1 Initial determinations with respect to employer and employee status.
259.2 Parties to determinations with respect to employer and employee status.
259.3 Reconsideration of initial determinations with respect to employer or employee status.
259.4 Authority to conduct investigations.
259.5 Appeals from decisions of the Board.
259.6 Finality of determinations issued under this part.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 362(l).

SOURCE: 43 FR 56889, Dec. 5, 1978, unless otherwise noted.

§ 259.1 Initial determinations with respect to employer and employee status.

(a) All requests for a determination with respect to employer or employee status shall be filed with the Secretary to the Board.

(b) The General Counsel of the Railroad Retirement Board or his or her designee shall make the initial investigations with respect to:

(1) The status of any person as an employer under the Railroad Retirement

Act and the Railroad Unemployment Insurance Act and the rules and regulations issued thereunder; and

(2) The status of any individual or group of individuals as an employee or employees of an employer covered under the Railroad Retirement Act and the Railroad Unemployment Insurance Act.

(c) Upon completion of this investigation the General Counsel, or his or her designee, shall submit to the Board the results of the investigation together with a recommendation concerning the coverage determination. The Board shall make the initial determination with respect to the status of any person as an employer or as an employee under the Railroad Retirement Act and Railroad Unemployment Insurance Act. The Secretary to the Board shall promptly notify the party or parties, as defined in §259.2 of this part, and other interested persons or entities of the Board's determination.

[57 FR 4366, Feb. 5, 1992]

§ 259.2 Parties to determinations with respect to employer and employee status.

(a) With respect to any determination under this part concerning the status of a person as an employer under the Railroad Retirement Act and the Railroad Unemployment Insurance Act, that person shall be a party to such determination and may submit written briefs or argument, as well as any documentary evidence pertinent to the matter at issue, to the decision maker to be considered in the rendition of a determination. The employees of such person may submit written briefs or argument with respect to such determination, but shall not be parties thereto.

(b) With respect to any determination under this part concerning the status of an individual or group of individuals as an employee or employees of an employer covered by the Railroad Retirement Act and the Railroad Unemployment Insurance Act, the employer alleged to be the employer of the individual or group of individuals and the individual or group of individuals shall each be considered a party to such determination and may submit written briefs or argument, and documentary evidence pertinent to the matter at issue, to the decision maker to be considered in the rendition of a determination.

§ 259.3 Reconsideration of initial determinations with respect to employer or employee status.

(a) A party to an initial decision issued under §259.1 shall have the right to request reconsideration of that decision. A request for reconsideration shall be in writing and must be filed with the Secretary to the Board within one year following the date on which the initial determination was issued. Where a request for reconsideration has been timely filed, the Secretary to the Board shall notify all other parties to the initial determination of such request. The party who requested reconsideration and any other party shall have the right to submit briefs or written argument, as well as any documentary evidence pertinent to the issue under consideration. The General Counsel or his or her designee shall review the material furnished all parties and shall submit it to the Board with a recommendation as to the determination upon reconsideration. The Board shall then issue a determination with respect to the request for reconsideration. The Secretary to the Board shall promptly notify all parties and other interested persons or entities of the determination upon reconsideration.

(b) A party who claims to be aggrieved by an initial decision of the Board but who fails to timely request reconsideration under this section shall forfeit any further right to appeal under this part.

[57 FR 4366, Feb. 5, 1992]

§ 259.4 Authority to conduct investigations.

In performing his or her responsibilites under §259.1 or §259.3, the General Counsel or his or her designee shall have the authority and the power to conduct any investigations he deems necessary. In addition, the General Counsel or his or her designee shall have the power to compel, by subpoena, any person, company, corporation, or other entity to produce any

records or other documents pertinent to the matter under consideration.

(45 U.S.C. 231f(b)(5))

[43 FR 56889, Dec. 5, 1978, as amended at 48 FR 51447, Nov. 9, 1983; 57 FR 4366, Feb. 5, 1992]

§ 259.5 Appeals from decisions of the Board.

A party who claims to be aggrieved by a decision of the Board under this part may obtain review of such decision by filing a petition for review in the United States court of appeals for the circuit in which the party resides or has its principal place of business or principal executive office, in the United States Court of Appeals for the Seventh Circuit, or in the United States Court of Appeals for the District of Columbia. The petition for review must be filed within 90 days following the date on which the notice of the Board's decision was mailed to that party.

[43 FR 56889, Dec. 5, 1978. Redesignated at 57 FR 4366, Feb. 5, 1992]

§ 259.6 Finality of determinations issued under this part.

Any determination rendered by the Board at the initial or reconsideration stages shall be considered a final determination and shall be binding with respect to all parties unless reversed on reconsideration or upon judicial review. A final determination may be reopened at the request of a party who was, or could have been, a party to the final determination when the party alleges that the law or the facts upon which the final determination was based have changed sufficiently to warrant a contrary determination. Such a request shall be submitted to the Secretary to the Board, who shall consider such request as a request for an initial determination under § 259.1.

[57 FR 4366, Feb. 5, 1992]

PART 260—REQUESTS FOR RECONSIDERATION AND APPEALS WITHIN THE BOARD

Sec.

260.1 Initial decisions.
260.2 Initial decisions on the amount of service and compensation credited to an employee.
260.3 Request for reconsideration of initial decision.
260.4 Request for waiver of recovery of an overpayment and/or for reconsideration of an initial erroneous payment decision.
260.5 Appeal from a reconsideration decision.
260.6 Time limits for issuing a hearing decision.
260.7 Time limits for issuing a decision when a hearing is not held.
260.8 Pre-hearing case review.
260.9 Final appeal from a decision of the hearings officer.
260.10 Determination of date of filing.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 231g; 45 U.S.C. 355.

SOURCE: 47 FR 36809, Aug. 24, 1982, unless otherwise noted.

§ 260.1 Initial decisions.

(a) *General.* Claims for benefits shall be adjudicated and initial decisions made by the Board concerning:

(1) Applications for benefits under the Railroad Retirement Act;

(2) The withdrawal of an application;

(3) A change in an annuity beginning date;

(4) The termination of an annuity;

(5) The modification of the amount of an annuity or lump-sum benefit;

(6) The reinstatement of an annuity which had been terminated or modified;

(7) The existence of an erroneous payment;

(8) The recovery of the amount of an erroneous payment;

(9) The eligibility of an individual for a supplemental annuity or the amount of such supplemental annuity;

(10) Whether representative payment shall serve the best interests of an annuitant as a result of that individual's incapacity to manage his annuity payments; and

(11) Who shall be designated or continued as representative payee on behalf of an annuitant.

(b) *Adjudication of claim and the issuance of initial decision.* Adjudication of a claim and the issuance of an initial decision shall be in accordance with instructions issued by the Board and shall be made upon the basis of evidence submitted by the claimant and evidence otherwise available.

(c) *Recovery of erroneous payment.* A decision to recover the amount of an erroneous payment under paragraph

(a)(8) of this section by suspension or reduction of a monthly benefit payable by the Board shall not be made prior to a date 30 calendar days after the date on which notice of the erroneous payment decision is sent to the beneficiary or payee of the benefit as provided in § 260.1(d)(6).

(d) *Notice of initial decision.* (1) In all cases except those described in paragraph (d)(2) through (4) and (6) of this section, written notice of an initial decision shall be mailed by the Board to the claimant, annuitant or payee of an annuity at the individual's last known address within 30 calendar days after such decision is made. Such notice shall inform the claimant, annuitant or payee of an annuity of the reason(s) for the decision and such individual's right to reconsideration of such initial decision as provided in § 260.3.

(2) No notice of an initial decision by the Board shall be required when the death of an annuitant causes the entitlement to an annuity to cease.

(3) When an initial decision is made that an annuitant's entitlement to a disability has ended, written notice of the decision shall be mailed to the annuitant or payee of an annuity at the annuitant's or payee's last known address. Such notice shall inform the annuitant or payee of an annuity:

(i) Of the date on which the recovery from disability is found to have occurred;

(ii) Of the reason(s) supporting such a finding of recovery;

(iii) That entitlement to the annuity ends on the last day of the second month after the month in which disability ends as described in § 220.181;

(iv) That the Board will stop payment of the annuitant's disability annuity with the last day of the second month following the month in which disability ends as described in § 220.181, or the last day of the first month following the month in which the notice provided by this paragraph is sent by the Board, whichever date is later:

(v) That any annuity payments received after entitlement has ended will have to be repaid unless waiver of recovery is appropriate;

(vi) That prior to the termination date of the annuity the annuitant or payee of an annuity may submit to the Board any information in writing which the annuitant or payee desires to be considered by the Board in its review;

(vii) That if no information in writing is received by the Board before the termination date the annuity will be terminated as scheduled on that date; and

(viii) That the annuitant or payee has the right to reconsideration of such decision as provided in § 260.3.

(4) When an initial decision would result in the termination of an annuity for which there are competing claims or as a result of the receipt by the Board of information from a source other than the annuitant or payee of an annuity, written notice of the proposed decision shall be mailed to the annuitant or payee of an annuity at such annuitant's or payee's last known address. Such notice shall inform the annuitant or payee of an annuity:

(i) Of the reason(s) for the annuity termination;

(ii) That the annuitant or payee has 30 calendar days from the date of the notice to submit to the Board any information in writing which such annuitant or payee desires to be considered by the Board in its review;

(iii) That payment of the annuity will either cease or a decision to continue payment of such annuity shall be made after the Board has considered any information in writing which may be submitted to the Board within 30 calendar days from the date of the notice;

(iv) That if no information in writing is received within 30 calendar days from the date of the notice, payment of the annuity will cease at the end of that 30-day period; and

(v) That the annuitant or payee has the right to reconsideration of such decision as provided in § 260.3.

(5) Whenever the Board receives any significant information in writing from an annuitant or payee of an annuity as a result of mailing the notice described in paragraph (d)(4) of this section, the Board shall forward a copy of such information to each of the individuals who has filed a competing claim for such annuity informing them that:

(i) The annuity will either be terminated at the specified time or a decision to continue payment of the annuity will be made by the Board; and

(ii) They may respond to such information and their response will be considered by the Board provided that it is received by the Board within a reasonable time. When the Board decision in such case is to continue payment of the annuity, the Board shall send notice of such initial decision to each of the competing claimants in accordance with paragraph (d)(1) of this section.

(6) When an initial decision that an erroneous payment has been made to a beneficiary is made under paragraph (a)(7) of this section, written notice of that decision shall be mailed to the beneficiary or payee of the benefit at such beneficiary's or payee's last known address within 30 calendar days after such decision is made. Such notice shall inform the beneficiary or payee:

(i) Of the reason(s) for the decision;

(ii) Of the methods by which recovery may be made;

(iii) Of the possibility of waiver of recovery of the erroneous payment;

(iv) Of the conditions which must be met before waiver of recovery could be granted;

(v) That the beneficiary may request waiver of recovery of the erroneous payment and/or reconsideration of the erroneous payment decision as provided in § 260.4; and

(vi) Of the possibility of an oral hearing with respect to the issues of waiver of recovery and reconsideration of the erroneous payment decision.

[47 FR 36809, Aug. 24, 1982, as amended at 55 FR 39146, Sept. 25, 1990; 56 FR 13040, Mar. 28, 1991; 67 FR 77153, Dec. 17, 2002]

§ 260.2 Initial decisions on the amount of service and compensation credited to an employee.

Within 30 days after receipt of a timely request by an employee for amendment with respect to the number of service months and amount of compensation credited to the employee by the Board under the Railroad Retirement Act and the Railroad Unemployment Insurance Act, the Board shall appoint a qualified employee to make a determination with respect to such matter. The employee appointed by the Board shall promptly render a decision. Written notice of such decision shall be communicated to the employee within 30 days after such decision is made. Such decision shall include notification of the employee's right to reconsideration of the initial decision as provided in § 260.3. For purposes of this section, a timely request to amend an employee's record of service months and compensation maintained under the Railroad Retirement Act shall be filed within four years after the date on which the report of service months and compensation was required to be made to the Board by the employee's employer. See § 211.16 of this chapter.

[67 FR 77153, Dec. 17, 2002]

§ 260.3 Request for reconsideration of initial decision.

(a) *Right to file request for reconsideration.* Every claimant shall have the right to file a request for reconsideration of an initial decision described in § 260.1(a) or in § 260.2. *Provided, however,* That:

(1) An individual under age 18 shall not have the right to reconsideration of a finding of incapacity to manage his or her annuity payments, but shall have the right to contest the finding that he or she is, in fact, under age 18;

(2) An individual who has been adjudged legally incompetent shall not have the right to reconsideration of a finding of incapacity to manage his or her annuity payments, but shall have the right to contest the fact of his or her having been adjudged legally incompetent; and

(3) An individual shall not have the right to reconsideration of a denial of his or her application to serve as representative payee on behalf of an annuitant. Such request for reconsideration shall be filed and disposed of in the manner prescribed in this section, except that a request for reconsideration of an initial erroneous payment decision under § 260.1(a)(7) shall be filed and disposed of in the manner prescribed in § 260.4.

(b) *Written request for reconsideration.* A written request for reconsideration may be filed with any office of the Board within 60 days from the date on which notice of the initial decision is

mailed to the claimant. The claimant shall state the basis for the reconsideration request and provide any additional evidence which is available. No hearing will be provided.

(c) *Right to further review of initial decision.* The right to further review of an initial decision shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in this section or good cause is shown by the claimant for failing to file a timely request for reconsideration.

(d) *Timely request for reconsideration.* In determining whether the claimant has good cause for failure to file a timely request for reconsideration the bureau director shall consider the circumstances which kept the claimant from filing the request on time and if any action by the Board misled the claimant. Examples of circumstances where good cause may exist include, but are not limited to:

(1) A serious illness which prevented the claimant from contacting the Board in person, in writing, or through a friend, relative or other person;

(2) A death or serious illness in the claimant's immediate family which prevented him or her from filing;

(3) The destruction of important and relevant records;

(4) A failure to be notified of a decision;

(5) An unusual or unavoidable circumstance existed which demonstrates that the claimant would not have known of the need to file timely or which prevented the claimant from filing in a timely manner; or

(6) The claimant thought that his or her representative had requested reconsideration.

(e) *Impartial review.* The reconsideration of the initial decision shall be conducted by a person who shall not have any interest in the parties or in the outcome of the proceedings, shall not have directly participated in the initial decision which has been requested to be reconsidered and shall not have any other interest in the matter which might prevent a fair and impartial decision.

(f) *Timely review.* The Board shall make every effort to issue a decision upon reconsideration and send a copy of the decision to the claimant within 60 days of the date that the decision for reconsideration is filed.

(g) *Right to appeal adverse decision.* If the reconsideration decision is adverse to the claimant, annuitant or payee, he or she shall be notifed of his or her right to appeal the decision to the Bureau of Hearings and Appeals, as provided in § 260.5.

[47 FR 36809, Aug. 24, 1982, as amended at 48 FR 51448, Nov. 9, 1983; 55 FR 39146, Sept. 25, 1990; 67 FR 77153, Dec. 17, 2002]

§ 260.4 Request for waiver of recovery of an overpayment and/or for reconsideration of an initial erroneous payment decision.

(a) *General.* A beneficiary who has been determined to have received an erroneous payment under § 260.1(a)(7) shall have the right, upon the filing of a timely request in accordance with the requirements of this section, to request waiver of recovery of the erroneous payment and/or reconsideration of the erroneous payment decision. The beneficiary shall have the right to an informal oral hearing on the issue of waiver of recovery and/or reconsideration of the erroneous payment decision, before an employee of the Board designated to conduct such a hearing, prior to commencement of recovery by suspension or reduction of a monthly benefit.

(b) *Request for waiver of recovery and/or reconsideration of an erroneous payment decision and for a personal conference.* A request for reconsideration of an erroneous payment decision must be filed in accordance with § 260.3(b) of this part. A request for waiver of recovery of an overpayment decision and for a personal conference under this section shall be in writing and addressed to the field office of the Board set forth in the initial decision letter or to the Debt Recovery Manager and shall be filed within 60 calendar days from the date on which notice of the overpayment decision was sent to the beneficiary. The beneficiary shall state in the request whether he or she elects to have a personal conference. If the beneficiary does not elect to have a personal conference with respect to his or her request for waiver of recovery or for reconsideration of the overpayment decision, he or she may, along with the

request, submit any evidence and argument which he or she would like to present in support of his or her case.

(c) *Right to further review of an initial overpayment decision.* The right to further review of an initial overpayment decision shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in § 260.3(b) of this part (60 days) or good cause, as defined in section 260.3(d) of this part, is shown by the beneficiary for failing to file a timely request for reconsideration. Nothing in this section shall be taken to mean that waiver of recovery will not be considered in these cases where the request for waiver is not filed within 60 days, but action to recover the erroneous payment will not be deferred if such a request is not filed within 60 days. Any amounts recovered prior to the date on which the request for waiver as permitted under the preceding sentence is filed shall not be waived under part 255 of this chapter.

(d) *Delay in commencement of recovery of erroneous payment.* Where a timely request for waiver or reconsideration is filed as provided in this section, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such request for waiver or reconsideration has been made and notice thereof mailed to the claimant.

(e) *Impartial review.* Upon receipt of a timely request for personal conference under this section, the Board shall promptly arrange for the selection of a Board employee to conduct a personal conference in the case. The employee designated to conduct the personal conference under this section shall not have had any prior involvement with the initial erroneous payment decision and shall conduct the personal conference in a fair and impartial manner. The employee designated to conduct the personal conference under this section shall promptly schedule a time and place for the personal conference and promptly notify the beneficiary of such. If the beneficiary agrees, the personal conference may be conducted by telephone.

(f) *Personal conference.* The beneficiary shall upon request have the opportunity to review, prior to the personal conference, his or her claim folder and all documents pertinent to the issues raised. A personal conference conducted under this section shall be informal. At the personal conference the beneficiary shall be afforded the following rights:

(1) To present his or her case orally and to submit evidence, whether through witnesses or documents;

(2) To cross-examine adverse witnesses who appear at the personal conference; and

(3) To be represented by counsel or other person.

(g) *Preparation of recommended decision.* Upon completion of the personal conference the employee who conducts the personal conference shall prepare a summary of the case including a statement of the facts, the employee's findings of fact and law, and a recommended decision.

(h) *Timely review.* The Board shall make every effort to render a decision with respect to the beneficiary's request for reconsideration of the initial erroneous payment determination and/or waiver of recovery and notify the beneficiary of that decision within 60 days of the date that the request for reconsideration and/or waiver is filed or the date that the summary of the case is received from the employee who conducts the personal conference, whichever is later.

(i) *Right to appeal adverse decision.* If the Board renders a decision adverse to the beneficiary, he or she may appeal the decision to the Bureau of Hearings and Appeals, as provided in § 260.5 of this part.

(j) *Repayment is not a bar to requesting waiver and/or reconsideration.* The fact that a beneficiary may have notified the Board with respect to the method by which he or she could choose to have the recovery made, or the fact that such beneficiary may have actually tendered to the Board a portion or

all of the amount of the erroneous payment, shall in no way operate to prejudice his or her right to request reconsideration of the initial erroneous payment determination or to request waiver of recovery.

[47 FR 36809, Aug. 24, 1982, as amended at 55 FR 39146, Sept. 25, 1990; 67 FR 77153, Dec. 17, 2002]

§ 260.5 Appeal from a reconsideration decision.

(a) *General.* Every claimant shall have a right to appeal to the Bureau of Hearings and Appeals from any reconsideration decision with which he or she disagrees.

(b) *Appeal from a reconsideration decision.* Appeal from a reconsideration decision shall be made by filing the form prescribed by the Board for such purpose. Such appeal must be filed with the Bureau of Hearings and Appeals within 60 days from the date upon which notice of the reconsideration decision is mailed to the claimant. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, provided that the claimant files the appeal form within the later of the 60-day period following the date of the reconsideration decision, or the 30-day period following the date of the letter sending the form to the claimant.

(c) *Right to review of a reconsideration decision.* The right to review of a reconsideration decision shall be forfeited unless an appeal is filed in the manner and within the time prescribed in this section. However, when a claimant fails to file an appeal with the Bureau of Hearings and Appeals within the time prescribed in this section, the hearings officer may waive this requirement of timeliness. Such waiver shall only occur in cases where the claimant has made a showing of good cause for failure to file a timely appeal. Good cause for failure to file a timely appeal will be determined by a hearings officer in the manner prescribed in § 260.3(d) of this part.

(d) *Delay in the commencement of recovery of erroneous payment.* Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the Bureau of Hearings and Appeals, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

(e) *Impartial review.* Within 30 days after the claimant has filed a proper appeal, the Director of Hearings and Appeals shall appoint a hearings officer to act on the appeal. The Director of Hearings and Appeals may, if the Bureau of Hearings and Appeals' caseload dictates, appoint a qualified Board employee, other than a hearings officer assigned to the Bureau of Hearings and Appeals, to act as a hearings officer with respect to a case. Such hearings officer shall not have any interest in the parties or in the outcome of the proceedings, shall not have directly participated in the initial decision or the reconsideration decision from which the appeal is made, and shall not have any other interest in the matter which might prevent a fair and impartial decision.

(f) *Power of hearings officer to conduct hearings.* In the development of appeals, the hearings officer shall have the power to hold hearings, require and compel the attendance of witnesses by subpoena or otherwise in accordance with the procedures set forth in part 258 of this chapter, administer oaths, rule on motions, take testimony, and make all necessary investigations.

(g) *Evidence presented in support of appeal.* (1) The appellant, or his or her representative, shall be afforded full opportunity to present testimony, or written evidence or exhibits upon any controversial question of fact; to examine and cross-examine witnesses; and to present argument in support of the appeal.

(2) The formal rules of evidence shall not apply; however, the hearings officer may exclude evidence which he or she finds is irrelevant or repetitious. Any evidence excluded by the hearings officer shall be described and that description made part of the record.

(3) If, in the judgment of the hearings officer, evidence not offered by the appellant is available and is relevant and material to the merits of the claim, the

hearings officer may obtain such evidence upon his or her own initiative. If new evidence is obtained after an oral hearing, other than evidence submitted by the appellant or his or her representative, the hearings officer shall provide the appellant or his or her representative with a copy of such evidence. In such event, the appellant shall have 30 days to submit rebuttal evidence or argument or to request a supplemental hearing to confront and challenge such new evidence. The appellant may move for an extension of time to submit rebuttal evidence or argument and the hearings officer may grant the motion upon a showing of good cause.

(h) *Submission of written argument in lieu of oral hearings.* Where the hearings officer finds that no factual issues are presented by an appeal, and the only issues raised by the appellant are issues concerning the application or interpretation of law, the appellant or his or her representative shall be afforded full opportunity to submit written argument in support of the claim but no oral hearing shall be held.

(i) *Conduct of an oral hearing.* (1) In any case in which an oral hearing is to be held, the hearings officer shall schedule a time and place for the conduct of the hearing. At the discretion of the hearings officer, any hearing required under this part may be held in person, by telephone conference call, or by video teleconferencing as described in § 260.5(1). The hearing shall not be open to the public. The hearings officer shall promptly notify by mail the party or parties to the proceeding as to the time and place for the hearing. The notice shall include a statement of the specific issues involved in the case. The hearings officer shall make every effort to hold the hearing within 150 days after the date the appeal is filed.

(2) If the appellant objects to the time or place of the hearing, he or she must notify the hearings officer no later than 5 calendar days before the time set for the hearing. The appellant must state the reason for his or her objection. If at all possible, the request should be in writing. The hearings officer will change the time or place of the hearing if he or she finds there is good cause to do so.

(3) The hearings officer shall rule on any objection timely filed by a party under paragraph (i) of this section and shall notify the party of his or her ruling thereon. The hearings officer may for good cause shown, or upon his or her own motion, reschedule the time and/or place of the hearing. If an individual objects to having a hearing by video teleconferencing, the hearings officer will find the individual's wish not to appear by video teleconferencing to be a good reason for changing the time or place of the scheduled hearing and will reschedule the hearing for a time or place where either a telephone conference call or an in person hearing will be held. The hearings officer may also limit or expand the issues to be resolved at the hearing.

(4) If neither a party nor his or her representative appears at the time and place scheduled for the hearing, that party shall be deemed to have waived his or her right to an oral hearing unless said party either filed with the hearings officer a notice of objection showing good cause why the hearing should have been rescheduled, which notice was timely filed but not ruled upon, or, within 10 days following the date on which the hearing was scheduled, said party files with the hearings officer a motion to reschedule the hearing showing good cause why neither the party nor his or her representative appeared at the hearing and further showing good cause as to why said party failed to file at the prescribed time any notice of objection to the time and place of the hearing.

(5) If the hearings officer finds either that a notice of objection was timely filed showing good cause to reschedule the hearing, or that the party has within 10 days following the date of the hearing filed a motion showing good cause for failure to appear and to file a notice of objection, the hearings officer shall reschedule the hearing. If the hearings officer finds that the hearing shall not be rescheduled, he or she shall so notify the party in writing.

(j) *Record of evidence considered.* The hearings officer will make a record of the material evidence. The record will include the applications, written statements, reports, and other documents

that were used in making the determination under review and any other additional evidence the appellant or any other party to the hearing presents in writing. If a hearing was held in the appeal, the tape recording of the hearing will be part of the record while the appeal is pending. The hearings officer's decision will be based on the record. The entire record at any time during the pendency of the appeal shall be available for examination by the appellant or by his or her duly authorized representative.

(k) *Extension of time to submit evidence.* Except where the hearings officer has determined that additional evidence not offered by the appellant at or prior to the hearing is available, the record shall be closed as of the conclusion of the hearing. The appellant may request an extension of time to submit evidence and the hearings officer will grant the request upon a showing of good cause for failure to have submitted the evidence earlier. The extension shall be for a period not exceeding 30 days.

(l) *Hearing by telephone or video teleconferencing.* As stated in paragraph (i)(1) of this section, at the discretion of the hearings officer, any hearing required under this part may be conducted in person, by telephone conference call, or by video teleconferencing. The hearings officer may determine the hearing should be conducted by telephone conference call or video teleconferencing if use of these methods would be more efficient than conducting an in person hearing and the hearings officer does not determine that there is a circumstance in the particular case preventing the use of these methodologies to conduct the hearing.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220-0007)

[67 FR 77154, Dec. 17, 2002 as amended at 71 FR 55283, Sept. 22, 2006]

§ 260.6 Time limits for issuing a hearing decision.

(a) *General.* The hearings officer shall make every effort to issue a decision within 45 days after the hearing is held.

(b) *Submission of additional evidence.* If the hearings officer requests additional evidence, he or she shall do so within 30 days after the hearing is held and he or she shall make every effort to issue the hearing decision within 45 days after the additional evidence is received and the period for comment has ended. If the claimant wishes to submit additional evidence or written statements of fact or law, the hearings officer shall make every effort to issue the hearing decision within 45 days after the written statements are received or the additional evidence is received and the period for comment has ended.

(c) *Supplemental hearing.* If on the basis of additional evidence the hearings officer decides a supplemental hearing is necessary, the supplemental hearing will be held within 30 days after the receipt of the additional evidence and the hearings officer shall make every effort to issue a decision within 30 days after the supplemental hearing is held.

(d) *Reassignment of case to another hearings officer.* If, after a hearing has been held, it is necessary to reassign a case to another hearings officer due to the unavailability of the original hearings officer (e.g., resignation, retirement, illness), the case will be promptly reassigned. The new hearings officer shall make every effort to issue a hearing decision within 30 days after the reassignment.

§ 260.7 Time limits for issuing a decision when a hearing is not held.

If a claimant waives his or her right to appear at a hearing and the hearings officer does not schedule the case for hearing, or the evidence in the record supports a favorable decision without a hearing, or a hearing is not required pursuant to § 260.5(g), the hearings officer shall make every effort to issue a decision within 90 days from the date the appeal is filed: *Provided, however,* that if the hearings officer requests additional evidence it shall be requested within 45 days of the filing of the appeal and the hearings officer shall make every effort to issue a decision within 30 days after the additional evidence is received and the appellant comments on the evidence, or if no comment is received after the close of the comment period.

§ 260.8 Pre-hearing case review.

(a) *General.* The hearings officer assigned to a case may, prior to an oral hearing, upon his or her own motion, refer the case back to the office of the Board which issued the initial decision for the purpose of reconsideration of that decision, where the hearings officer finds that:

(1) Additional evidence pertinent to the resolution of the issues on appeal was submitted by the appellant at the time the appeal was filed, or subsequent thereto; or

(2) Additional evidence pertinent to the resolution of the issues on appeal is available and should be procured; or

(3) There is some other indication in the record that the initial decision may be revised in a manner favorable to the appellant.

(b) *Referral of case for further review by initial adjudicating unit.* Where the hearings officer finds that referral of a case back to the office which issued the initial decision for the purpose of reconsideration of that decision would be warranted, the hearings officer shall give that office the reason for such referral, together with specific directions as to the handling of the case on reconsideration.

(c) *Reconsideration of case by initial adjudicating unit.* The office to which a case is referred shall promptly undertake any additional development required, and shall make a determination as to whether the initial determination may be revised in whole or in part in a manner favorable to the appellant. Upon issuance of its determination, the office in question shall return the case along with a copy of its decision to the hearings officer.

(d) *Revision of initial decision in whole or in part.* Where the office to which a case is referred determines to revise its initial decision in whole or in part, that office shall notify the appellant of such determination. If the revised determination is wholly favorable to the appellant, he or she shall be notified that the appeal to the Bureau of Hearings and Appeals will be dismissed by the hearings officer assigned to the case. If the revised decision is partially favorable to the appellant, the notice shall inform the appellant that the hearings officer will proceed with the portion of the appellant's case not revised in his or her favor, unless the appellant should request dismissal of the appeal.

(e) *Timely conduct of oral hearing.* The fact that a case on appeal has been referred back to the office which issued the initial decision in the case shall not delay the conduct of a hearing scheduled with respect to the appeal, unless the appellant agrees to a delay. If it appears that the office to which a case has been referred will not have completed its reconsideration of the case prior to the date of a scheduled hearing on an appeal and the appellant has not agreed to a delay in the conduct of the hearing, the hearings officer shall proceed with the hearing and the handling of the case as though the case had not been referred back to the office.

[47 FR 36809, Aug. 24, 1982, as amended at 67 FR 77155, Dec. 17, 2002]

§ 260.9 Final appeal from a decision of the hearings officer.

(a) *General.* Every appellant shall have a right to a final appeal to the Railroad Retirement Board from any decision of a hearings officer by which he or she claims to be aggrieved.

(b) *Appeal from decision of hearings officer.* Final appeal from a decision of a hearings officer shall be made by the execution and filing of the final appeal form prescribed by the Board. Such appeal must be filed with the Board within 60 days from the date upon which notice of the decision of the hearings officer is mailed to the appellant at the last address furnished by him or her. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, *Provided that* the claimant files the appeal form within the later of the 60-day period following the date of the hearing officer's decision, or the 30-day period following the date of the letter sending the form to the claimant.

(c) *Timely filing.* The right to further review of a decision of a hearings officer shall be forfeited unless formal final appeal is filed in the manner and within the time prescribed in § 260.9(b). However, when a claimant fails to file an appeal before the Board within the

time prescribed in this section, the Board may waive this requirement if, along with the final appeal form, the appellant in writing requests an extension of time. The request for an extension of time must give the reasons why the final appeal form was not filed within the time limit prescribed in this section. If in the judgment of the Board the reasons given establish that the appellant had good cause for not filing the final appeal form within the time prescribed, the Board will consider the appeal to have been filed in a timely manner. The Board will use the standards found in § 260.3(d) of this chapter in determining if good cause exists.

(d) *Delay in the commencement of recovery of erroneous payment.* Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the three-member Board, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

(e) *Submission of additional evidence.* Upon final appeal to the Board, the appellant shall not have the right to submit additional evidence. However, the Board may grant a request to submit new evidence where new and material evidence is available that, despite due diligence, was not available before the decision of the hearings officer was issued. The Board may also obtain new evidence on its own motion. Upon admission of new evidence, the Board, at its discretion, may:

(1) Vacate the decision of the hearings officer and remand the case to the Bureau of Hearings and Appeals for issuance of a new decision. The decision of the hearings officer on remand may be appealed to the Board in the manner described in paragraph (b) of this section; or

(2) Return the case to the hearings officer for further consideration with direction to submit a recommended decision to the Board.

(f) *Decision of the Board.* The decision of the Board shall be made upon the record of evidence developed by the hearings officer and any additional evidence admitted pursuant to paragraph (e) of this section. The appellant may submit additional argument in writing with the appeal to the Board. The appellant shall have no right to an oral presentation before the Board except where the Board so permits. Such presentation shall be limited in form, subject matter, length, and time as the Board may indicate to the appellant.

(g) *Issuance of decision.* The Board shall make every effort to issue a decision within 90 days after the later of:

(1) The date the final appeal is filed;

(2) The date new or better evidence is obtained in accordance with § 260.9(d) and the appellant has commented on it;

(3) The date new or better evidence is obtained in accordance with § 260.9(d) and after the close of the comment period;

(4) The date further argument submitted in accordance with § 260.9(e) is received; or

(5) The date the record is returned to the Board following referral back to the hearings officer.

(h) *Review of decisions rendered prior to appeal to Board.* The Board may, on its own motion, review or cause to be reviewed any decision issued by a subordinate official or employee under this part.

(The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 3220–0007)

[47 FR 36809, Aug. 24, 1982, as amended at 50 FR 19523, May 9, 1985; 52 FR 11017, Apr. 6, 1987; 67 FR 77155, Dec. 17, 2002; 68 FR 6820, Feb. 11, 2003]

§ 260.10 Determination of date of filing.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section, for purposes of this part, a document or form is filed on the day it is received by an office of the Board or by an employee of the Board who is authorized to receive it at a place other than one of the Board's offices.

(b) *Other dates of filing.* The Board will also accept as the date of filing the date a document or form is mailed to the Board by the United States mail, if using the date the Board receives it would result in the loss or lessening of

rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, the Board will consider other evidence of when the document or form was mailed to the Board.

[67 FR 77156, Dec. 17, 2002]

PART 261—ADMINISTRATIVE FINALITY

Sec.
261.1 Reopening and revising decisions.
261.2 Conditions for reopening.
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261.11 Discretion of the three-member Board to reopen or not to reopen a final decision.

AUTHORITY: 45 U.S.C. 231f.

SOURCE: 62 FR 45713, Aug. 29, 1997, unless otherwise noted.

§ 261.1 Reopening and revising decisions.

(a) This part sets forth the Board's rules governing finality of decisions. After the expiration of the time limits for review as set forth in part 260 of this chapter, decisions of the agency may be reopened and revised under the conditions described in this part, by the bureau, office, or entity that made the earlier decision or by a bureau, office, or other entity at a higher level, which has the claim properly before it.

(b) A *final decision* as that term is used in this part means any decision of the type listed in § 260.1 of this chapter where the time limits for review as set forth in part 260 of this chapter or in the Railroad Retirement Act have expired.

(c) *Reopening* a final decision under this part means a conscious determination on the part of the agency to reconsider an otherwise final decision for purposes of revising that decision.

(d) *New and material evidence* as that phrase is used in this part means evidence that may reasonably be expected to affect a final decision, which was unavailable to the agency at the time the decision was made, and which the claimant could not reasonably have been expected to have submitted at that time.

§ 261.2 Conditions for reopening.

A final decision may be reopened:

(a) Within 12 months of the date of the notice of such decision, for any reason;

(b) Within four years of the date of the notice of such decision, if there is new and material evidence or there was adjudicative error not consistent with the evidence of record at the time of adjudication; or

(c) At any time if:

(1) The decision was obtained by fraud or similar fault;

(2) Another person files a claim on the same record of compensation and allowance of the claim adversely affects the first claim;

(3) A person previously determined to be dead on whose earnings record a survivor annuity is based is found to be alive;

(4) A claim was denied because of the absence of proof of death of the employee, and the death is later established:

(i) By reason of an unexplained absence from his or her residence for a period of 7 years; or

(ii) By location or identification of his or her body;

(5) The Social Security Administration has awarded duplicate benefits on the same record of compensation;

(6) The decision was that the claimant did not have an insured status, and compensation has been credited to the employee's record of compensation in accordance with part 211 of this chapter:

(i) To enter items transferred by the Social Security Administration which were credited under the Social Security Act when they should have been credited to the employee's railroad retirement compensation record; or

(ii) To correct an error made in the allocation of earnings to an individual which, if properly allocated, would

have given him or her an insured status at the time of the decision and the evidence of these earnings was in the possession of the Railroad Retirement Board or the Social Security Administration at the time of the decision;

(7) The decision is wholly or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination or decision was made;

(8) The decision found the claimant entitled to an annuity or to a lump sum payment based on the earnings record of a deceased person, and it is later established that:

(i) The claimant was convicted of a felony or an act in the nature of a felony for intentionally causing that person's death; or

(ii) If the claimant was subject to the juvenile justice system, he or she was found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony;

(9) The claimant shows that it is to his or her advantage to select a later annuity beginning date and refunds, by cash payment or setoff, past payments applying to the period prior to the later beginning date, subject, however, to the provisions of subpart D of part 217 and § 218.9 of this chapter;

(10) The decision is incorrect because of a failure to apply a reduction, or the proper reduction, to the tier I component of an annuity, but the Board shall apply the reduction only for the months following the month the Board first takes corrective action.

(d) Revision of the amount or payment of a separation allowance lump sum amount pursuant to section 6(e) of the Railroad Retirement Act is limited to 60 days from the date of notification of the award of the separation allowance lump sum payment.

§ 261.3 Change of legal interpretation or administrative ruling.

A change of legal interpretation or administrative ruling upon which a decision is based does not render a decision erroneous and does not provide a basis for reopening.

§ 261.4 Decisions which shall not be reopened.

The following decisions shall not be reopened:

(a) An award of an annuity beginning date to an applicant later found to have been in compensated service to an employer under part 202 of this chapter on that annuity beginning date and who is found not to be at fault in causing the erroneous award; provided, however, that this exception shall not operate to permit payment of benefits for any month in which the claimant is found to be engaged in compensated service.

(b) An award of an annuity based on a subsequently discovered erroneous crediting of months of service and compensation to a claimant where:

(1) The loss of such months of service and compensation will cause the applicant to lose his or her eligibility for an annuity previously awarded;

(2) The erroneously credited months of service do not exceed six months; and

(3) The annuitant is found not to be at fault in causing the erroneous crediting.

(c) An erroneous award of an annuity where the error is no greater than one dollar per month per annuity affected.

(d) An erroneous award of a lump sum or accrued annuity payment where the error is no greater than $25.00.

§ 261.5 Late completion of timely investigation.

(a) A decision may be revised after the applicable time period in § 261.2(a) or § 261.2(b) of this part expires if the Railroad Retirement Board begins an investigation into whether to revise the decision before the applicable time period expires and the agency diligently pursues the investigation to the conclusion. The investigation may be based on a request by a claimant or on action by the Railroad Retirement Board.

(b) *Diligently pursued* for purposes of this section means that in view of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if the investigation is concluded

and, if necessary, the decision is revised within 6 months from the date the investigation began.

(c) If the investigation is not diligently pursued to its conclusion, the decision will be revised if a revision is applicable and if it is favorable to the claimant. It will not be revised if it would be unfavorable to the claimant.

§ 261.6 Notice of revised decision.

(a) When a decision is revised, notice of the revision will be mailed to the parties to the decision at their last known address. The notice will state the basis for the revised decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a hearings officer or the three-member Board proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, all parties will be notified in writing of the proposed action. If a revised decision is issued by a hearings officer, any party may request that it be reviewed by the three-member Board, or the three-member Board may review the decision on its own initiative.

§ 261.7 Effect of revised decision.

A revised decision is binding unless:

(a) The revised decision is reconsidered or appealed in accord with part 260 of this chapter;

(b) The three-member Board reviews the revised decision; or

(c) The revised decision is further revised consistent with this part.

§ 261.8 Time and place to request review of a revised decision.

A party to a revised decision may request, as appropriate, further review of the decision in accordance with the rules set forth in part 260 of this chapter.

§ 261.9 Finality of findings when later claim is filed on same earnings record.

If two claims for benefits are filed on the same record of compensation, findings of fact made in a decision in the first claim may be revised in determining or deciding the second claim, even though the time limit for revising the findings made in the first claim has passed. However, a finding in connection with a claim that a person was fully or currently insured at the time of filing an application, at the time of death, or any other pertinent time, may be revised only under the conditions stated in § 261.2 of this part.

§ 261.10 Increase in future benefits where time period for reopening has expired.

If, after the time period for reopening under § 261.2(b) of this part has expired, new evidence is furnished showing a different date of birth or new evidence is furnished which would cause a correction in a record of compensation as provided for in part 211 of this chapter and, as a result of the new evidence, increased benefits would be payable, the Board will pay increased benefits, but only for the months following the month the new evidence is received.

§ 261.11 Discretion of the three-member Board to reopen or not to reopen a final decision.

In any case in which the three-member Board may deem proper, the Board may direct that any decision, which is otherwise subject to reopening under this part, shall not be reopened or direct that any decision, which is otherwise not subject to reopening under this part, shall be reopened.

PART 262 [RESERVED]

PART 266—REPRESENTATIVE PAYMENT

Sec.

266.1 Introduction.
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266.3 Information considered in determining whether to make representative payments.
266.4 Information considered in selecting a representative payee.
266.5 Order of preference in selecting a representative payee.
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266.8 Advance notice of the determination to make representative payment.

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266.10 Use of benefit payments.
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266.13 When a new representative payee will be selected.
266.14 When representative payment will be stopped.
266.15 Transfer of accumulated benefit payments.

AUTHORITY: 45 U.S.C. 231k and 231f.

SOURCE: 59 FR 3992, Jan. 28, 1994, unless otherwise noted.

§ 266.1 Introduction.

(a) *Explanation of representative payment.* This part explains the principles and procedures that the Board follows in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds which he or she receives on behalf of an annuitant. A representative payee may be either a person or an organization selected by the Board to receive benefits on behalf of an annuitant. A representative payee will be selected if the Board believes that the interest of an annuitant will be served by representative payment rather than direct payment of benefits. Generally, the Board will appoint a representative payee if it determines that the annuitant is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Statutory authority.* Section 12 of the Railroad Retirement Act provides that every annuitant and claimant shall be conclusively presumed to have been competent until the date on which the Board receives a notice in writing that a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor has been appointed: Provided, however, That despite receiving such notice, the Board may, if it finds the interests of such annuitant or claimant to be served thereby, recognize actions by, conduct transactions with, and make payments to such annuitant or claimant.

(c) *Policy used to determine whether to make representative payment.* (1) In accordance with section 12 of the Railroad Retirement Act, the Board's policy is that every annuitant has the right to manage his or her own benefits. However, some annuitants due to mental or physical condition or due to their youth may be unable to do so. If the Board determines that the interests of an annuitant would be better served if benefit payments were certified to another person as representative payee, the Board will appoint a representative payee in accordance with the procedures set forth in this part. The Board may appoint a representative payee even if the annuitant is a legally competent individual. If the annuitant is a legally incompetent individual, the Board may appoint the legal guardian or some other person as a representative payee.

(2) If payment is being made directly to an annuitant and a question arises concerning his or her ability to manage or direct the management of benefit payments, the Board may, if the annuitant is 18 years old or older and has not been adjudged legally incompetent, continue to pay the annuitant until the Board makes a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 266.2 Recognition by the Board of a person to act in behalf of another.

(a) Regardless of the receipt of written notice of the appointment of a guardian or other person legally vested with the care of the person or estate of an incompetent or a minor who is receiving or claiming benefits or to whom any right or privilege is extended under the law, the Board may, in its discretion, validly recognize actions by and conduct transactions with others acting on behalf of the individual found by the Board to be a minor or to be unable to manage his or her affairs, if the Board finds such actions or transactions to be in the best interest of such individual.

(b) In the absence of a written notice of the appointment of a guardian or other person legally vested with the care of the person or estate of an incompetent or minor, the Board shall,

except where special circumstances appear, recognize a person to act on behalf of an individual under the following circumstances:

(1) When the individual has been adjudged mentally incompetent by a court having jurisdiction to do so;

(2) When the individual has been committed to a mental institution by a court having jurisdiction to do so;

(3) When the individual is an inmate of a mental institution;

(4) When the individual is less than 16 years of age; or

(5) When the individual is between 16 and 18 years of age and is in the care of another person and does not have the capacity to act on his or her own behalf.

§ 266.3 Information considered in determining whether to make representative payments.

In determining whether to make representative payment, the Board may consider the following information:

(a) *Evidence of legal guardianship.* Evidence of the appointment of a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor shall be a certified copy of the court's determination.

(b) *Medical evidence.* The Board may use medical evidence, when such is available, to help determine whether an annuitant is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the annuitant and his or her knowledge of the annuitant's present condition will be used in the Board's determination, if it includes information concerning the nature of the annuitant's illness, the annuitant's chances for recovery and the opinion of the physician or other medical professional as to whether the annuitant is able to manage or direct the management of benefit payments.

(c) *Other evidence.* The Board may also consider statements of relatives, friends, and other people in a position to know and observe the annuitant, which contain information helpful to the Board in deciding whether the annuitant is able to manage or direct the management of benefit payments.

§ 266.4 Information considered in selecting a representative payee.

In selecting a representative payee, the Board tries to select the person, agency, organization or institution that will best serve the interest of the annuitant. In making this selection, the Board may consider such factors as the following:

(a) The relationship of the person to the annuitant, including the type of relationship, *e.g.*, family or legal guardianship; degree of relationship, if the person is a family member; and the length of association, if a non-family member;

(b) The amount of interest that the person shows in the annuitant, including the contributions the person makes to the welfare of the annuitant and the contacts and frequency of such contacts with the annuitant;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the annuitant;

(d) Whether the potential payee has custody of the annuitant;

(e) Whether the potential payee is in a position to know of and look after the needs of the annuitant;

(f) Verification of the social security account number, name, address, telephone number, place of employment, and main source of income if applicable, accepted as part of any person's application for designation as a representative payee, unless such person's identification has already been established to the satisfaction of the Board;

(g) Whether an applicant for designation as a representative payee has ever been convicted of a felony or misdemeanor under the statutes administered by the Board or the Social Security Act, or convicted of a felony under any other Federal or State law; and

(h) Whether the services of such person as representative payee have previously been terminated, suspended, or declined by the Board or the Social Security Administration for:

(1) Misuse of the benefits of the annuitant for whom they were intended;

(2) Failure to comply with any provision of or regulation under the Railroad Retirement Act or the Social Security Act; or

(3) Failure to meet the requirements of this part.

(i) Whether the potential payee is a creditor of the annuitant. A creditor who provides goods and services to the annuitant ordinarily may not serve as a representative payee unless such appointment poses no substantial conflict of interest and unless the creditor is:

(1) A relative who resides with the annuitant;

(2) A legal guardian or legal representative of the annuitant; or

(3) A licensed or certified care facility (or owner, administrator or employee thereof) where there annuitant resides.

§ 266.5 Order of preference in selecting a representative payee.

As a guide in selecting a representative payee, categories of preferred payees have been established. These preferences are flexible. The primary concern of the Board is to select the payee who will best serve the annuitant's interest. The preferences are:

(a) For annuitants 18 years old or older, the preference is:

(1) A legal guardian, spouse, or other relative who has custody of the annuitant or who demonstrates strong concern for the personal welfare of the annuitant;

(2) A friend who has custody of the annuitant or demonstrates strong concern for the personal welfare of the annuitant;

(3) A public or nonprofit agency or institution having custody of the annuitant;

(4) A private institution operated for profit and licensed under State law, which has custody of the annuitant; and

(5) Persons other than those listed above who are qualified to carry out the responsibilities of a representative payee and who are able and willing to serve as a payee for an annuitant; *e.g.*, members of community groups or organizations who volunteer to serve as representative payee for an annuitant.

(b) For annuitants under age 18, the preference is:

(1) A natural or adoptive parent who has custody of the annuitant, or a legal guardian;

(2) A natural or adoptive parent who does not have custody of the annuitant, but is contributing toward the annuitant's support and is demonstrating strong concern for the annuitant's well-being;

(3) A relative or stepparent who has custody of the annuitant;

(4) A natural or adoptive parent who does not have custody of the annuitant and is not contributing toward his or her support but is demonstrating strong concern for the annuitant's well-being;

(5) A relative who does not have custody of the annuitant but is contributing toward the annuitant's support and is demonstrating concern for the annuitant's well-being;

(6) A relative or close friend who does not have custody of the annuitant but is demonstrating concern for the annuitant's well-being; and

(7) An authorized social agency or custodial institution.

§ 266.6 Information to be submitted by a representative payee-applicant; face-to-face interview.

Before the Board selects a representative payee, the Board may request the payee-applicant to provide information concerning the factors listed in § 266.4 of this part. An employee of the Board may also conduct a face-to-face interview with the payee-applicant.

(Approved by the Office of Management and Budget under control number 3220–0052)

§ 266.7 Accountability of a representative payee.

(a) A representative payee is accountable for the use of benefits. The Board will require periodic written reports from representative payees. The Board may also, at the Board's option, verify how a representative payee used benefit payments. A representative payee must keep records of what was done with all benefit payments in order to make accounting reports. The Board may ask the following questions:

(1) The amount of benefit payments on hand at the beginning of the accounting period;

(2) How the benefit payments were used;

(3) How much of the benefit payments were saved and how the savings were invested;

(4) Where the annuitant lived during the accounting period;

(5) The amount of the annuitant's income from other sources during the accounting period. The Board may ask for information about other funds to enable the Board to evaluate the use of benefit payments; and

(6) Whether the representative payee has been convicted of a felony or misdemeanor offense under the statutes administered by the Board or by the Social Security Administration within the past 15 years or whether any such charges are pending.

(b) An individual to whom payments are certified as representative payee on behalf of an annuitant shall submit a written report in such form and at such times as the Board may require, accounting for the payments certified to him or her on behalf of the annuitant. If, however, such payee is a court-appointed fiduciary and, as such, is required to make an annual accounting to the court, a true copy of each such account filed with the court may be submitted in lieu of the accounting form prescribed by the Board. If any representative payee fails to submit the required accounting within a reasonable period of time after it is requested, no further payments shall be made to him or her on behalf of the annuitant unless for good cause shown, the default of the representative payee is excused by the Board, and the required accounting is thereafter submitted.

(c) At any time after the Board has selected a representative payee, the Board may ask such payee to submit information showing a continuing relationship to the annuitant and a continuing responsibility for the care of the annuitant. If the representative payee does not give the Board the requested information within a reasonable period of time, the Board may stop paying such payee unless the Board determines that the payee had a good reason for not complying with the Board's request, and the Board receives the information requested.

(Approved by the Office of Management and Budget under control numbers 3220–0052 and 3220–0151)

(d) Where, pursuant to paragraph (b) or (c) of this section, the Board suspends payments, such suspension shall not exceed a period of 30 days; thereafter, the payments will be made to the annuitant except where the annuitant is an unemancipated minor under age 18 or where in the Board's judgment the interests of the annuitant would not be served by releasing payment to the annuitant.

§ 266.8 Advance notice of the determination to make representative payment.

(a) As a general rule, whenever the Board intends to make representative payment and to name a representative payee, the Board will notify the annuitant or, in the case of an unemancipated minor under age 18, or an individual who is legally incompetent, the individual acting on his or her behalf of the Board's proposed actions. Such notice will tell the person that the Board plans to name a representative payee and who that payee will be. The notice will also ask the person to contact the Board within 15 days of the date of the notice if he or she objects to either proposed action. If he or she objects to either proposed action, the objecting party may—

(1) Review the evidence upon which the proposed actions will be based; and

(2) Submit any additional evidence regarding the proposed actions.

(b) If the objecting party objects to the proposed actions, the Board will review its proposed determinations and consider any additional information provided. The Board will then issue a decision on whether to appoint a representative payee and who that payee will be. If the objecting party is dissatisfied with either determination, he or she may request a reconsideration under part 260 of this chapter.

(c) If the objecting party does not file a timely objection to the proposed actions, the Board will issue a decision on whether to appoint a representative payee and who that payee will be. If the objecting party is dissatisfied with

either determination, he or she may request a reconsideration under part 260 of this chapter.

(d) A request for reconsideration or an appeal from a determination under this section under part 260 of this chapter shall not prevent the Board from making payments to a representative payee during the pendency of such reconsideration or appeal.

(e) The Board's failure or refusal to select an individual as representative payee or the Board's termination of representative payee status with respect to an individual is not subject to a request for reconsideration or an appeal under part 260 of this chapter by such individual.

§ 266.9 Responsibilities of a representative payee.

(a) A representative payee shall, subject to review by the Board and to such requirements as it may from time-to-time prescribe, apply the payments made to him or her on behalf of the annuitant only for the use and benefit of such annuitant, and in a manner and for purposes which are in the annuitant's best interests.

(b) A representative payee shall notify the Board of any event that will affect the amount of benefits the annuitant receives or the right of the annuitant to receive benefits.

(c) A representative payee shall notify the Board of any change in his or her circumstances that would affect performance of the payee responsibilities.

§ 266.10 Use of benefit payments.

(a) *Current maintenance.* Payments made to an individual as representative payee on behalf of an annuitant shall be considered as having been applied for the use and benefit of the annuitant when they are used for the annuitant's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care, and personal comfort items.

Example: An aged annuitant is entitled to a monthly railroad retirement benefit of $800. His son, who is his representative payee, disburses his benefits in the following manner:

Rent and utilities	$500
Medical	50
Food	80
Clothing(coat)	90
Savings	60
Miscellaneous	20

The above expenditures would represent proper disbursements on behalf of the annuitant.

(b) *Institutional care.* If an annuitant is receiving care in a Federal, state, or private institution because of mental or physical incapacity, current maintenance includes the customary charges made by the institution in providing care and maintenance, as well as expenditures for those items which will aid in the annuitant's recovery or release from the institution or expenses for personal needs which will improve the annuitant's conditions while in the institution.

(c) *Support of legal dependents.* If the current maintenance needs of the annuitant are met, the representative payee may use part of the payments for the support of the annuitant's legally dependent spouse, child, and/or parent.

(d) *Claims of creditors.* Where a debt arose prior to the first month for which benefits are certified to a representative payee, the representative payee may satisfy such debt out of present benefit payments only if the current and reasonably foreseeable needs of the annuitant are met.

Example: A retroactive railroad retirement annuity check in the amount of $2,100, representing benefits due for November 1989 through January 1990, was issued on behalf of the annuitant to the annuitant's daughter, who is the representative payee. The check was certified in February 1990. The nursing home, where the annuitant resides, is owed money for maintenance expenses the annuitant incurred prior to February 1990.

If the accrual is not required for the annuitant's current maintenance and the annuitant had no foreseeable needs which would require large disbursements, the expenditure of the accrual or part thereof for the past due maintenance charges would be consistent with the Board's guidelines.

§ 266.11 Conservation and investment of benefit payments.

(a) *General.* If benefit payments made to a representative payee are not needed for the annuitant's current maintenance or reasonably foreseeable needs or the support of legal dependents or to pay creditors in accordance with

§ 266.10, they shall be conserved or invested on behalf of the annuitant. Such funds must be invested in accordance with the rules applicable to investment of trust estates by trustees. Any investment must show clearly that the representative payee holds the property in trust for the annuitant.

(b) *Preferred investments.* Preferred investments for excess funds are deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law, direct obligations of the United States Government or obligations for which both principal and interest are guaranteed unconditionally by the United States Government. The account must be in a form which shows clearly that the representative payee has only a fiduciary, and not a personal, interest in the funds. If the payee is the legally appointed guardian or fiduciary of the annuitant, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

_____
(Name of annuitant)

_____
(Social Security Number), for whom

_____
(Name of payee)

is representative payee for Railroad Retirement benefits;

(2) For interest or dividend paying accounts—

_____
(Name of annuitant) by

_____
(Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the annuitant and may not be considered to be the property of the representative payee.

(d) *Prohibition against commingling.* The representative payee shall not commingle his or her personal funds with the representative payments. A representative payee may consolidate and maintain an annuitant's funds in an account with other annuitants if he or she maintains a separate, accurate and complete accounting of each annuitant's funds under his or her control.

§ 266.12 Effect of matters or actions submitted or taken by legal guardian, etc.

All matters and actions in connection with an annuity submitted or taken by the guardian or other person legally vested with the care of the person or estate of an incompetent or a minor shall be considered by the Board in the same manner and with the same effect as though such matters or actions had been submitted or taken by the ward, if the ward had capacity to act in his or her own behalf; *Provided, however,* That the Board may, if it deems it necessary, require the guardian or other person legally vested with the care of the person or estate of an incompetent or a minor to submit a certified copy of an order from the court of appointment authorizing some particular action which the guardian or other person legally vested with the care of the person or estate desires to take in connection with the application.

§ 266.13 When a new representative payee will be selected.

When the Board learns that the interests of the annuitant are not served by continuing payment to the present representative payee or that the present representative payee is no longer able to carry out the payee responsibilities, the Board will undertake to find a new representative payee. The Board will select a new representative payee if the Board finds a preferred payee or if the present payee—

(a) Has not used the benefit payments on the annuitant's behalf in accordance with the guidelines in this part;

(b) Has not carried out the other responsibilities described in this part;

(c) Dies;

(d) No longer wishes to be representative payee;

(e) Is unable to manage the benefit payments; or

(f) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information which the Board requests.

§ 266.14 When representative payment will be stopped.

If an annuitant receiving representative payment shows the Board that he or she is mentally and physically able to manage or direct the management of benefit payments, the Board will make direct payment to the annuitant. Information which the annuitant may give to the Board to support his or her request for direct payment include the following:

(a) A physician's statement regarding the annuitant's condition, or a statement by a medical officer of the institution where the annuitant is or was confined, showing that the annuitant is able to manage or direct the management of his or her funds;

(b) A certified copy of a court order restoring the annuitant's rights in a case where an annuitant was adjudged legally incompetent; or

(c) Other evidence which establishes the annuitant's ability to manage or direct the management of benefits.

§ 266.15 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested funds from railroad retirement payments made to him or her on behalf of an annuitant shall, upon direction of the Board, transfer any such funds (including interest or dividends earned from investment of such funds) to a successor representative payee appointed by the Board, or, at the option of the Board, shall transfer such funds, including interest, to the Board for payment to a successor payee or to the annuitant.

PART 295—PAYMENTS PURSUANT TO COURT DECREE OR COURT-APPROVED PROPERTY SETTLEMENT

Sec.

295.1 Introduction.
295.2 Definitions.
295.3 Documentation and service.
295.4 Review of documentation.
295.5 Limitations.
295.6 Disclosure of information.
295.7 Miscellaneous.

AUTHORITY: 45 U.S.C. 231f; 45 U.S.C. 231m.

SOURCE: 51 FR 12845, Apr. 16, 1986, unless otherwise noted.

§ 295.1 Introduction.

(a) *Purpose.* This part implements section 419 of Pub. L. 98–76 (97 Stat. 438), which amended section 14 of the Railroad Retirement Act to provide that, with respect to annuity amounts payable for months beginning with September 1983, the Board must comply with a court decree of divorce, annulment or legal separation, or with the terms of any court-approved property settlement incident to any such decree, which characterizes specified benefits as property subject to distribution. Garnishment of benefits for alimony or child support is dealt with in part 350 of this chapter.

(b) *Benefits subject to this part.* Only the following benefits or portions of benefits under the Railroad Retirement Act are subject to this part:

(1) Employee annuity net tier II benefit component as provided under section 3(b) of the Railroad Retirement Act;

(2) Employee annuity vested dual benefit component as provided under section 3(h) of the Act;

(3) Employee annuity net proportionate share of the annuity increases as provided under section 3(f) of the Act; and

(4) Supplemental annuities as provided under section 2(b) of the Act.

§ 295.2 Definitions.

As used in this part—

Act means the Railroad Retirement Act.

Court means any court of competent jurisdiction of any state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands; any court of the United States (as defined in section 451 of title 28 of the United States Code) having competent jurisdiction; any Indian court as defined by section 1301 of title 25 of the United States Code; or any court of competent jurisdiction of a foreign country with which the United States has an agreement requiring the United States to honor any court order of such country.

Court decree means a final decree of divorce, dissolution, annulment, or

legal separation issued by a court (including a final decree or order modifying the terms of a previously issued decree of divorce, dissolution, annulment, or legal separation), which is issued in accordance with the laws of the jurisdiction of that court and which provides for the division of property.

Division of property means any transfer of property or its value by an individual to his or her spouse or former spouse in compliance with any community property settlement, equitable distribution of property, or other distribution of property between spouses or former spouses, which is intended as a present and complete settlement of the property rights of the parties.

Employee means an individual who is or was formerly an employee as defined by part 203 of this chapter.

Final decree means a decree from which no appeal may be taken or from which no appeal has been taken within the time allowed for taking such appeals under the laws applicable to such appeals, or a decree from which timely appeal has been taken and such appeal has been finally decided under the laws applicable to such appeals.

Property settlement means an agreement between the parties to a suit for divorce, dissolution, annulment or legal separation in which they expressly agree to a division of their property rights, and which is incorporated in the final decree; is filed with the court in connection with a suit for divorce, dissolution, annulment or legal separation; or is otherwise presented to the court in a suit in accordance with the law of the jurisdiction. An agreement assigning or transferring property between spouses is not within the purview of this part unless it is subsequently approved by a court in connection with a suit for divorce, dissolution, annulment or legal separation.

Spouse or former spouse means the husband or wife, or former husband or wife, respectively, of an employee who, on or before the date of a court order, was married to the employee.

§ 295.3 Documentation and service.

(a) *Court decree or property settlement.* The Board will honor a court decree or a property settlement which meets the following criteria:

(1) The court decree or property settlement must provide that the spouse or former spouse is awarded payments from railroad retirement annuities payable to the railroad employee.

(2) The court decree or property settlement must specify an amount to be paid to the spouse or former spouse.

(3) The court decree or property settlement must obligate the Board to make payments directly to the spouse or former spouse.

(4) The court decree or property settlement must clearly identify both the employee and the spouse or former spouse to whom payments are to be made.

(5) The court decree or property settlement submitted to the Board must be a recently certified copy of the document filed with the court. Where the award is made in an order modifying and earlier court decree, copies of both the original decree and the subsequent order must be furnished. In the case of a court-approved property settlement, both the settlement and any decree or order incorporating or approving the settlement must be provided.

(b) *Date of decree.* While only benefits payable for months after August, 1983 are subject to this part, the date the decree is entered or the property settlement is approved may precede September 1, 1983. A subsequent modification of a decree which was entered or a property settlement which was approved prior to September 1, 1983 must be in accord which the law of the jurisdiction in which the original decree was entered or the property settlement was approved.

(c) *Supporting documentation.* The spouse or former spouse shall submit such additional documentation as the Board shall require, including but not limited to:

(1) Identifying information concerning the employee such as social security number, railroad retirement claim number, full name, date of birth, and current address.

(2) Identifying information concerning the spouse or former spouse such as social security number, full name, and current address.

(3) A statement that—

(i) No condition of the law of the jurisdiction in which the decree was entered or the property settlement approved and no condition contained in the decree or agreement which requires termination of payment has occurred;

(ii) If any such condition does occur, the spouse or former spouse will immediately notify the Board; and

(iii) The spouse or former spouse agrees to repay any erroneous payment arising from occurrence of any such condition.

(d) *Delivery*. Any court decree or property settlement must be delivered by certified or registered mail, return receipt requested, or by personal service, to the Deputy General Counsel of the Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. Where the decree or property settlement is delivered to any other office of the Board, it shall not be considered delivered until the date it is received by the Deputy General Counsel. Where the decree or property settlement was furnished to any office of the Board prior to September 1, 1983, delivery is not accomplished until a copy is received by the Deputy General Counsel subsequent to August 30, 1983.

(Approved by the Office of Management and Budget under control number 3220–0042)

§ 295.4 Review of documentation.

(a) *Regularity*. The Deputy General Counsel or his or her designee shall review the court decree or property settlement to determine that it complies with both the law of the jurisdiction, and with Federal law and these regulations.

(b) *Amount*. Ambiguities in the amount to be paid the spouse or former spouse shall be resolved in accord with expressed indications of the court's intent, except that:

(1) Where the amount is expressed in terms of a dollar figure:

(i) If the figure exceeds the total benefits which may be allocated under this part, the excess will be disregarded, provided that any future increase in the benefits subject to this part will be prospectively applied to the excess effective with the date of the benefit increase.

(ii) If the figure is less than the total benefits which may be allocated under this part, only the amount specified will be paid.

(2) Where the amount is expressed as a fraction, percentage, or ratio:

(i) The amount specified shall be applied only against benefits subject to this part, irrespective of the wording of the decree or property settlement.

(ii) When the amount is expressed in terms of a fraction or ratio referring to the length of railroad service, years shall be converted into the equivalent months. If the length of railroad service specified in the decreee or property settlement exceeds the number of creditable service months used by the Board to determine the employee's years of service for calculating an annuity, the actual number used by the Board shall bs substituted. If the decree understates the actual number of creditable railroad service months, the number of years or months set forth in the decree or property settlement will be used.

(3) An amount may be expressed in any other fashion only to the extent to which it may be readily ascertained from records maintained by the Board in the regular course of administration of the Act.

(c) *Notification*. The Deputy General Counsel or his or her designee shall make reasonable effort to notify the spouse or former spouse and the employee of a determination that the decree or property settlement does or does not qualify as a decree or property settlement which will be honored pursuant to this part. This notice will be mailed to the most recent address of each party or representative of each party as shown in the Board's records. A copy of the decree or property settlement will be provided to the employee with this notice. The notice must state:

(1) The rationale for a determination that the decree or property settlement does not comply with this part; or

(2) The dollar amount or proportion of benefits which will be paid to the spouse or former spouse.

(d) *Withholding after notification*. (1) Where the Deputy General Counsel or his or her designee has notified the spouse or former spouse that a decree or property settlement will be honored

under this part, but where the employee is not then entitled to any benefits subject to division under this part, the Associate Executive Director for Retirement Claims will notate the Board's records to reflect both the amount of benefits awarded to the spouse or former spouse pursuant to the decree or property settlement and his or her current address. Where the employee is currently entitled to benefits subject to this part, and the spouse or former spouse has furnished all additional documentation required, the Associate Executive Director for Retirement Claims will take action to withhold from the employee's monthly benefit the amount stated in the Deputy General Counsel's notice under paragraph (c) of this section that the Board will honor the decree or property settlement.

(2) Where the employee was not entitled to benefits subject to this part at the time of the notice by the Deputy General Counsel that the Board will honor the decree or property settlement, but the employee becomes so entitled at a later time, the Board will attempt to contact the spouse or former spouse at the most recent address shown in the Board's records. The notice will inform the spouse or former spouse that an annuity has been awarded, that the spouse or former spouse may, upon submission of all required documentation, receive a portion of the annuity, and that the spouse or former spouse should contact the Board within three months from the date of the notice. The Associate Executive Director for Retirement Claims will initiate withholding of the amount awarded to the spouse or former spouse from the employee's monthly benefit, and will continue to withhold this amount for three successive months; provided, that an initial annuity payment for a retroactive period shall count as one monthly benefit payment. If after the third month's payment has been withheld the Board has received no response from the spouse or former spouse, the amount withheld from the employee's benefit shall be paid to the employee, and the Board take no further action regarding the decree until the spouse or former spouse contacts the board.

(3) Benefits withheld from the employee may not be paid to a spouse or former spouse until the spouse or former spouse has furnished all supporting documentation required pursuant to § 295.3 of this part. The Board shall allow a reasonable time, not to exceed three months from the date of the initial response from the spouse or former spouse, for the submission of all required documentation. If the documentation is not furnished within the time allowed, payment of the amounts withheld shall be made to the employee.

(4) Any payments made to the employee subsequent to the three-month notice period specified in paragraphs (d)(2) and (3) of this section, and prior to receipt of a response or required documentation from the spouse or former spouse, shall be considered properly paid to the employee and the board shall have no further liability to the spouse or former spouse with respect to such amounts.

§ 295.5 Limitations.

(a) *Employee benefit entitlement.* Payments will be made to a spouse or former spouse under this part only if the employee has been awarded an annuity under the Railroad Retirement Act. Payments to a spouse or former spouse shall be made only for months and from such amounts with respect to which an annuity is payable to the employee, and shall be suspended or terminated for any month in which the annuity of the employee is suspended or terminated. No arrearage accrues to the spouse or former spouse with respect to any month for which the annuity of the employee is suspended or reduced as required under the Act.

(b) *Minimum amount.* The amount of payment to a spouse or former spouse may not be less than one dollar per month.

(c) *Prospective payment.* Payment to a spouse or former spouse may accrue no earlier than the later of the date of delivery, pursuant to § 295.3 of this part, of a court decree or property settlement which will be honored under this part, or from October 1, 1983. The amount to be paid the spouse or former

spouse under this part will not be increased to satisfy an arrearage due from the employee.

(d) *Payees.* Payment of an amount awarded to a spouse or former spouse by a court decree or property settlement will be made only to the spouse or former spouse except where the Board determines that another person shall be recognized to act in behalf of the spouse or former spouse as provided by part 266 of this chapter, relating to incompetence. Payment will not be made to the heirs, legatees, creditors or assignees of a spouse or former spouse, except that where an amount is payable to a spouse or former spouse pursuant to this part, but is unpaid at the death of that spouse or former spouse, the unpaid amount may be paid in accordance with §234.1 of this chapter, pertaining to employee annuities unpaid at death.

(e) *Net amount of benefits.* Notwithstanding the terms of the decree or property settlement, the amount of benefits payable to the employee which are subject to this part shall not include:

(1) Amounts deducted to satisfy a debt due the United States, including any amount withheld to recover erroneous payments under the Railroad Retirement Act, Railroad Unemployment Insurance Act, or any other acts administered by the Board; and

(2) Benefits which are waived pursuant to §243.6 of this chapter.

(f) *Termination.* Payments to a spouse or former spouse terminate on the earlier of—

(1) The date on which the employee annuity terminates;

(2) The date required by the court decree or property settlement or the law of the jurisdiction in which the court decree or property settlement was entered; or

(3) The last day of the month before the month in which the spouse or former spouse dies.

(g) *Priority.* In the event that the Deputy General Counsel receives more than one decree or property settlement from competing parties, benefits shall be available to satisfy the decrees or property settlements on a first come, first served basis governed by the date of receipt by the Deputy General Counsel. Conflicting decrees or property settlements received on the same day shall be accorded priority based upon the earliest date upon which the decree or property settlement became final.

[51 FR 12845, Apr. 16, 1986, as amended at 53 FR 35807, Sept. 15, 1988; 62 FR 67724, Dec. 30, 1997]

§ 295.6 Disclosure of information.

(a) *Immunity from process.* The provision for the payment of benefits under this part pursuant to a court decree or property settlement shall not be construed to be a waiver of the sovereign immunity of the Railroad Retirement Board as an agency of the U.S. Government. The Board may not be joined in a suit for divorce, dissolution, annulment or legal separation, or otherwise subjected to the jurisdiction of any state court. Subpoenas, notices of joinder, interrogatories, orders for production of documents, and like state process issued in connection with a suit for divorce, dissolution, annulment or legal separation will be treated as requests for disclosure of information under this section.

(b) *Request for information.* A response to request for information to be used in connection with a suit for divorce, dissolution, annulment or legal separation may be made by the Deputy General Counsel or his or her designee, by the Associate Executive Director for Retirement Claims, or by a contact representative of the Board's field service.

(c) *Information available.* In the absence of signed authorization from the employee, a spouse or former spouse who is a party to a suit for divorce, dissolution, annulment or legal separation, or his or her legal representative, may be furnished the amount of benefits the employee is currently receiving. If the employee is not currently entitled to benefits, the Board may furnish the amount of any estimated benefit to which the employee would be entitled if he or she were of retirement age at the time of the request, as reflected by the records of the Board, to the extent it is possible for the Board to compute such amount. The Board shall not be required to furnish the present value of future benefits, the amount of benefits payable at a future

date, or any other computations based on statistics or procedures not maintained by the Board in the normal course of administration of the Act.

(d) *Certification.* A letter or statement prepared by a Board official in the regular course of duty from the official records of the Board, which refers to the authority of this section and bears his or her signature, shall be a sufficient response for purposes of discharging the responsibilities of the Board under this section. A certification in accordance with this section may be considered a public document for purposes of admissibility as evidence of present or potential benefits under the Act for use in a divorce, dissolution, annulment or legal separation proceeding.

§ 295.7 Miscellaneous.

(a) *Disbursement cycle.* In honoring and complying with a court decree or property settlement, the Board shall not be required to disrupt its normal disbursement cycle, despite any special schedule of accrual or payment of amounts due the spouse or former spouse set forth in the decree or settlement. A decree or settlement received too late to be honored during the disbursement cycle in which it was received shall be honored with respect to the next payment due the employee.

(b) *Liability for payments.* Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to a court decree or property settlement regular on its face, if such payment is made in accordance with this part.

(c) *Liability for disclosures.* No employee of the Board whose duties include responding to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in making such response.

(d) *Applicable law.* For purposes of a proceeding under this part, the Board will apply the law of the jurisdiction in which the court decree or property settlement was issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any jurisdiction with significant interest in the matter.

(e) *Erroneous payments.* If a spouse or former spouse receives a payment pursuant to this part from an employee's benefit, and the Board later determines that the employee was not entitled to all or part of those benefits for any month, the amount of the employee's benefits which was paid to the spouse or former spouse in excess of the amount which was actually payable shall be an erroneous payment to the spouse or former spouse within the meaning of section 10 of the Railroad Retirement Act.

SUBCHAPTER C—REGULATIONS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT

PART 300—DEFINITIONS

AUTHORITY: Sec. 12, 52 Stat. 1107, as amended; 45 U.S.C. 362. Interprets or applies sec. 1, 52 Stat. 1094, as amended; 45 U.S.C. 351.

§ 300.1 Words and phrases.

For the purposes of the regulations in this part, except where the language or context indicates otherwise:

(a) The term ''act'' means the Railroad Unemployment Insurance act.

(b) The term ''employer'' means an employer as defined in the act and part 201 of this chapter.

(c) The term ''Board'' means the Railroad Retirement Board.

(d) The term ''person'' includes an individual, trust, estate, partnership, association, joint stock company, company, corporation, and institution.

(e) The term ''United States'', when used in a geographical sense, means the States and the District of Columbia.

(f) The term ''State'' means any of the States or the District of Columbia.

(g) The term ''employment'' means service performed as an employee.

(h) The term ''local lodges and divisions'' and the term ''local lodge or division'' as used in section 1(a) and 1(d), respectively, of the act, shall be construed to include any subordinate unit of a national railway labor organization defined as an ''employer'' under the act, which unit functions in the same manner as, or similar to ''local lodges'' as that term is ordinarily used, irrespective of the designation of such unit by its national organization.

[Board Order 40–368 and Board Order 40–385, 5 FR 2717, Aug. 1, 1940, as amended by Board Order 68–72, 33 FR 11114, Aug. 6, 1968]

PART 301—EMPLOYERS UNDER THE ACT

Sec.

301.1 Statutory provisions.
301.4 Who are employers.

AUTHORITY: 45 U.S.C. 362(1).

§ 301.1 Statutory provisions.

(a) The term ''employer'' means any carrier (as defined in subsection (b) of this section), and any company which is directly or indirectly owned or controlled by one or more such carriers or under common control therewith, and which operates any equipment or facility or performs any service (except trucking service, casual service, and the casual operation of equipment or facilities) in connection with the transportation of passengers or property by railroad, or the receipt, delivery, elevation, transfer in transit, refrigeration or icing, storage, or handling of property transported by railroad, and any receiver, trustee, or other individual or body, judicial or otherwise, when in the possession of the property or operating all or any part of the business of any such employer: *Provided, however,* That the term ''employer'' shall not include any street, interurban, or suburban electric railway, unless such railway is operating as a part of a general steam-railroad system of transportation, but shall not exclude any part of the general steam-railroad system of transportation now or hereafter operated by any other motive power. The Interstate Commerce Commission is hereby authorized and directed upon request of the Board, or upon complaint of any party interested, to determine after hearing whether any line operated by electric power falls within the terms of this proviso. The term ''employer'' shall also include railroad associations, traffic associations, tariff bureaus, demurrage bureaus, weighing and inspection bureaus, collection agencies, and other associations, bureaus, agencies, or organizations controlled and maintained wholly or principally by two or more employers as hereinbefore defined and engaged in the performance of services in connection with or incidental to railroad transportation; and railway labor organizations, national in scope, which have been or may be organized in accordance with the provisions of the Railway Labor Act, and their State and National legislative committees and their general committees and their insurance departments and their local lodges and divisions, established pursuant to the constitution and bylaws of such organizations.

The term ''employer'' shall not include any company by reason of its being engaged in the mining of coal, the supplying of coal to an employer where delivery is not beyond the mine tipple, and the operation of equipment or facilities therefor, or in any of such activities. * * *

(b) The term ''carrier'' means an express company, sleeping-car company, or carrier

by railroad, subject to part I of the Interstate Commerce Act.

[Board Order 40–368, 5 FR 2718, Aug. 1, 1940, as amended by Board Order 41–526, 7 FR 97, Jan. 6, 1942]

§ 301.4 Who are employers.

The provisions of § 201.1(k) and the provisions of §§ 202.2 through 202.15 of this chapter shall be applicable to the determination of who are employers under the Railroad Unemployment Insurance Act to the same extent and in the same manner as they are applicable to the determination of who are employers under the Railroad Retirement Act of 1937.

[Board Order 40–368, 5 FR 2718, Aug. 1, 1940]

PART 302—QUALIFIED EMPLOYEE

Sec.
302.1 Introduction.
302.2 Definitions.
302.3 Qualifying conditions.
302.4 Nonqualifying earnings or payments.
302.5 Accelerated benefit year.
302.6 Publication requirements.
302.7 Establishing base year service and compensation.

AUTHORITY: 45 U.S.C. 362(1).

SOURCE: 56 FR 6966, Feb. 21, 1991, unless otherwise noted.

§ 302.1 Introduction.

This part sets forth the base year service and compensation required of an employee to qualify for benefits under the Railroad Unemployment Insurance Act with respect to a benefit year. Under the Act, only employees who satisfy the qualifying conditions of section 3 of the Act may be paid benefits. No provision is made for payment of dependents benefits for an employee's spouse or children. A qualified employee who claims benefits must demonstrate that he or she is eligible for benefits in accordance with the other provisions of the Act and this chapter. However, a qualified employee who is disqualified under any of the provisions of section 4 of the Act does not forfeit his or her status as a qualified employee.

§ 302.2 Definitions.

Base year. The term ''base year'' means the completed calendar year immediately preceding the beginning of the benefit year.

Benefit year. The term ''benefit year'' means the 12-month period beginning July 1 of any year and ending June 30 of the next year. If a registration period begins in June and ends in July, the benefit year ending date is deemed to be the last day of such registration period. If an employee is eligible for payment of extended benefits, the benefit year ending date for such employee will be June 30, or the last day of his or her extended benefit period, whichever date is later.

Compensation. The term ''compensation'' means generally any form of earnings or money remuneration earned on the basis of railroad employment during any month, excluding any amount in excess of the monthly compensation base for that month and also excluding payments of the character described in § 302.4 of this part.

Monthly compensation base. The term ''monthly compensation base'' means the greater of $600, or the amount calculated using the following formula:

$$\mathrm{MCB} = 600\left(1 + \frac{\mathrm{A} - 37{,}800}{56{,}700}\right)$$

For the purpose of this formula, ''MCB'' is the dollar amount of the monthly compensation base, and ''A'' is the amount of the Tier I tax base under section 3231(e)(2) of the Internal Revenue Code for the calendar year for which the monthly compensation base is being computed. If the dollar amount computed under this formula is not a multiple of $5, it shall be rounded to the nearest multiple of $5. If the dollar amount computed is equidistant between two multiples of $5, it shall be rounded up the nearest multiple of $5.

Registration period. With respect to unemployment benefits, the term ''registration period'' has the meaning given in § 325.1(c) of this chapter. With respect to sickness benefits, the term ''registration period'' has the meaning given in § 335.1(d) of this chapter.

[56 FR 6966, Feb. 21, 1991; 56 FR 10302, Mar. 11, 1991]

§ 302.3 Qualifying conditions.

(a) *Basic requirements.* To qualify for benefits with respect to a benefit year, an employee:

(1) Must have earned compensation in an amount equal to at least 2.5 times the amount of the monthly compensation base during his or her base year; and

(2) If such employee has earned no compensation prior to such base year, he or she must have earned compensation in at least five months during his or her base year.

(b) *Deemed service months disregarded.* For purposes of paragraph (a) of this section, service months deemed under § 210.3 of this chapter shall be disregarded.

§ 302.4 Nonqualifying earnings or payments.

The following types of earnings or payments do not count as compensation for the purpose of determining whether an employee has satisfied the base year qualifying conditions:

(a) Compensation earned as an employee representative, as defined in part 205 of this chapter, or as an employee of a local lodge or division of a railway labor organization;

(b) Tips;

(c) Payments under nongovernmental plans for unemployment, maternity or sickness insurance;

(d) Personal injury settlements or judgments, unless a portion thereof represents pay for time lost;

(e) Wages from employment that is subject to the Federal Unemployment Tax Act;

(f) Earnings from self-employment or investments;

(g) Pay for military service;

(h) Remuneration for service which is performed by a nonresident alien individual for the period he or she is temporarily present in the United States as a nonimmigrant under subparagraph (F) or (J) of section 101(a)(15) of the Immigration and Nationality Act, as amended, and which is performed to carry out the purpose specified in subparagraph (F) or (J), as the case may be; and

(i) Any payment that is not subject to contributions under section 8 of the Railroad Unemployment Insurance Act.

[56 FR 6966, Feb. 21, 1991; 56 FR 10302, Mar. 11, 1991]

§ 302.5 Accelerated benefit year.

(a) *Eligibility conditions.* An employee who is not a qualified employee with respect to the benefit year in effect at the time of his or her application for benefits may be eligible for an ''accelerated'' benefit year if he or she meets all of the following conditions.

(1) The employee has 10 or more years of service, as defined in part 210 of this chapter, prior to the beginning of his or her current period of unemployment or sickness;

(2) The employee has satisfied the qualifying conditions as defined in § 302.3 of this part with respect to the next succeeding benefit year;

(3) The employee's current period of unemployment or sickness includes at least 14 consecutive days of unemployment or 14 consecutive days of sickness; and

(4)(i) If the applicant is claiming unemployment benefits, he or she did not voluntarily leave work without good cause or did not voluntarily retire, or

(ii) If the applicant is claiming sickness benefits, he or she has not attained age 65 or has not voluntarily retired.

(b) *Beginning date of benefit year.* An accelerated benefit year begins on the first day of the month during which the employee's period of 14 consecutive days of unemployment or 14 consecutive days of sickness begins. Thus, for example, if an eligible employee has 14 consecutive days of unemployment from May 29–June 11, his or her benefit year beginning date is May 1, that is, he or she does not have to wait until July 1 to begin receiving benefits. If such employee also had a claim for the period May 15 to May 28, such claim may then be compensable or may serve as the waiting period even though the claim did not consist of 14 days of unemployment. His or her benefit year ends June 30 of the following year.

(c) *Effect of attaining age 65.* If a benefit year begins early for the purpose of paying sickness benefits and the employee attains age 65 before July 1 of

the general benefit year, sickness benefits may not be paid for any day from the day on which the employee attained age 65 up to and including June 30, but unemployment benefits may be paid in this interim period if the employee is otherwise eligible. Sickness benefits may be paid for days of sickness beginning July 1 or later. If a benefit year begins early for the purpose of paying unemployment benefits, attainment of age 65 will have no effect on the employee's rights to sickness benefits, other than extended sickness benefits, in the accelerated benefit year. An employee is deemed to attain age 65 on the day before his or her sixty-fifth birthday.

§ 302.6 Publication requirements.

(a) *Publication of base year compensation requirement.* On or before December 1 of each year, the Railroad Retirement Board will compute the amount of base year compensation that an employee must have during the following calendar year in order to be a qualified employee on the basis of such compensation. Within 10 days of such computation, the Board will publish a notice in the FEDERAL REGISTER of the amount so computed and will notify each employer of that amount. Information as to such qualifying amount may also be obtained from any district or regional office of the Railroad Retirement Board or from the Bureau of Unemployment and Sickness Insurance.

(b) *Notices.* The Board will provide employers with notices of their employees' rights to benefits under the Railroad Unemployment Insurance Act. The Board will arrange with employers to post such notices in such numbers and in such places as may be necessary to ensure that they will be seen by the greatest number of employees.

§ 302.7 Establishing base year service and compensation.

(a) *Employer reports.* In determining whether an applicant for benefits is a qualified employee, the Board will rely initially upon reports of base year service and compensation provided by employers in accordance with part 209 of this chapter.

(b) *No employer report located.* If the Board cannot locate the employer's report of base year service and compensation for an applicant, the applicant will be afforded an opportunity, by completing the form prescribed by the Board, to provide such other statement, information, evidence or documentation to establish his or her status as a qualified employee. An employee's claim for credit for service or compensation that is not shown in the Board's records of service and compensation shall be verified in accordance with §§ 210.7 and 211.14 of this chapter.

(c) *Employer fails to report.* When an employer has failed or refuses to file a report under part 209 of this chapter, an employee may establish his or her base year service and compensation by submitting:

(1) Statements, under oath or otherwise, signed by an official or duly authorized employee of a Federal or State governmental agency, based upon reports to the agency by the employer; or

(2) Statements, under oath or otherwise, signed by an officer or a duly authorized employee of the employer, or if not so signed, on forms prepared by the employer.

(Approved by the Office of Management and Budget under control numbers 3220–0025 and 3220–0070)

PART 319—PROCEDURE FOR DETERMINING LIABILITY FOR CONTRIBUTIONS OR REPAYMENTS OF BENEFITS

Sec.

319.1 Statutory provisions.
319.2 Procedure for determining entitlement to benefits awarded where employer status is denied, and for determining liability for contributions.

AUTHORITY: Sec. 12, 52 Stat. 1107, as amended; 45 U.S.C. 362.

§ 319.1 Statutory provisions.

* * * In any case in which benefits are awarded to a claimant in whole or in part upon the basis of pay earned in the service of a person or company found by the Board to be an employer as defined in this Act but which denies that it is such an employer, such benefits awarded on such basis shall be

paid to such claimant subject to a right of recovery of such benefits. The Board shall thereupon designate one of its officers or employees to receive evidence and to report to the Board on whether such benefits should be repaid. The Board may also designate one of its officers or employees to receive evidence and report to the Board whether or not any person or company is entitled to a refund of contributions or should be required to pay contributions under this Act, regardless of whether or not any claims for benefits will have been filed upon the basis of service in the employ of such person or company, and shall follow such procedure if contributions are assessed and payment is refused or payment is made and a refund claimed upon the basis that such person or company is or will not have been liable for such contributions. In any such case the Board or the person so designated shall, by publication or otherwise, notify all parties properly interested of their right to participate in the proceeding and, if a hearing is to be held, of the time and place of the hearing. At the request of any party properly interested the Board shall provide for a hearing, and may provide for a hearing on its own motion. The Board shall prescribe regulations governing the proceedings provided for in this paragraph and for decisions upon such proceedings.

Final decision of the Board in the cases provided for in the preceding two paragraphs shall be communicated to the claimant and to the other interested parties within fifteen days after it is made. Any properly interested party notified, as hereinabove provided, of his right to participate in the proceedings may obtain a review of any such decision by which he claims to be aggrieved or the determination of any issue therein in the manner provided in subsection (f) of this section with respect to the review of the Board's decisions upon claims for benefits and subject to all provisions of law applicable to the review of such decisions. Subject only to such review, the decision of the Board upon all issues determined in such decision shall be final and conclusive for all purposes and shall conclusively establish all rights and obligations, arising under this Act, of every party notified as hereinabove provided of his right to participate in the proceedings.

Any issue determinable pursuant to this subsection and subsection (f) of this section shall not be determined in any manner other than pursuant to this subsection and subsection (f). (Section 5(c), Railroad Unemployment Insurance Act.)

In any proceeding other than a court proceeding, the rules of evidence prevailing in courts of law or equity shall not be controlling, but a full and complete record shall be kept of all proceedings and testimony, and the Board's final determination, together with its findings of fact and conclusions of law in connection therewith, shall be communicated to the parties within fifteen days after the date of such final determinations.

(Section 5(e), Railroad Unemployment Insurance Act.)

Any claimant, or any railway labor organization organized in accordance with the provisions of the Railway Labor Act, of which claimant is a member, or any other party aggrieved by a final decision under subsection (c) of this section, may, only after all administrative remedies within the Board will have been availed of and exhausted, obtain a review of any final decision of the Board by filing a petition for review within ninety days after the mailing of notice of such decision to the claimant or other party, or within such further time as the Board may allow, in the United States court of appeals for the circuit in which the claimant or other party resides or will have had his principal place of business or principal executive office, or in the United States Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia. * * * (Section 5(f), Railroad Unemployment Insurance Act.)

[Board Order 58–142, 23 FR 9089, Nov. 22, 1958]

§ 319.2 Procedure for determining entitlement to benefits awarded where employer status is denied, and for determining liability for contributions.

(a) The Board may designate one of its officers or employees as examiner to receive evidence and report to the Board (1) whether or not a claimant should repay benefits awarded in whole or in part upon the basis of pay earned in the service of a person or company found by the Board to be an employer as defined in the Railroad Unemployment Insurance Act, but which denies that it is such an employer, or (2) whether or not any person or company is entitled to a refund of contributions or should be required to pay contributions under the Act. Such procedure shall be followed if contributions are assessed and payment is refused or payment is made and a refund claimed upon the basis that such person or company is or will not have been liable for such contributions. The examiner shall have power to hold hearings, require and compel the attendance of witnesses, administer oaths, take testimony, and make all necessary investigations. At the request of any party properly interested, the Board shall

provide for a hearing before such examiner, and may provide for a hearing on its own motion. The examiner shall, by publication or otherwise, notify all parties properly interested of their right to participate in the proceeding and if a hearing is to be held, of the time and place of the hearing.

(b) All evidence and argument presented by any party, and all evidence developed by the examiner, shall be preserved and shall constitute a part of the record. All oral evidence presented at any hearing, and all oral argument, shall be reduced to writing. The record at any time shall be available for examination by any properly interested party or his representative.

(c) Upon the completion of any proceeding, the examiner shall upon the basis of the entire record, render a report to the Board as soon as practicable, and within five days after the making thereof shall send a copy of the report to each party appearing in the proceeding by mailing such copy to him at the address stated in his appearance. Such report shall contain a statement of (1) the issue or issues raised, (2) the evidence submitted, (3) findings of fact, (4) conclusions of law, and (5) a recommended determination.

(d) Any party to the proceeding may, within twenty days after the mailing to him of a copy of the examiner's report, file with the Board, and serve upon other parties by mailing to their addresses as stated in their appearances, such exceptions in writing as he desires to make to the examiner's findings of fact and conclusions of law. Each exception shall specifically designate the particular finding of fact or conclusion of law to which exception is taken, and shall set forth in detail the grounds of the exception. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered. Each party shall have ten days after the receipt of exceptions taken by other parties in which to file with the Board replies to the exceptions. The Board may, upon the application of any party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The examiner's report shall be advisory but shall be presumed to be correct. Findings of fact to which no exceptions are taken will, subject only to the power of the Board to reject or modify, stand confirmed.

(e) The Board will render its decision upon the record and upon the basis of the examiner's report and such exceptions and replies thereto as are made. Further argument will not be permitted except upon a showing by any party that he has arguments to present which for valid reasons he was unable to present at an earlier stage, and in cases in which the Board requests further elaboration of arguments. In such cases, the further argument shall be submitted orally or in writing, as the Board may indicate in each case, and shall be subject to such restrictions as to form, subject matter, length, and time as the Board may indicate. The decision of the Board will be communicated to all parties to the proceeding within fifteen days after it has been made by mailing a copy of the decision to each such party at the address furnished by him.

(f) The decision of the Board, with respect to all issues determined therein, shall be final and conclusive for all purposes, and shall conclusively establish all rights and obligations, arising under any act administered by the Board, of every person notified of his right to participate in the proceeding.

(g) Any properly interested party notified of his right to participate in the proceeding may, as provided in section 5(c) of the Railroad Unemployment Insurance Act, and in accordance with the provisions of section 5(f) of the Act, obtain judicial review of a final decision of the Board, under this section, by which he claims to be aggrieved, by filing a petition for review in the proper court within ninety days after the mailing to him of notice of such decision, or within such further time as the Board may allow. Such petition for review must be filed in the U.S. Court of Appeals for the circuit in which the party resides or will have had his principal place of business or principal executive office, or in the U.S. Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia.

(h) Insofar as applicable and not inconsistent with the preceding provisions of this section, the provisions of §§250.7 to 250.16 of this chapter shall be followed in any proceeding under this section.

[Board Order 58–142, 23 FR 9089, Nov. 22, 1958]

PART 320—INITIAL DETERMINATIONS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT AND REVIEWS OF AND APPEALS FROM SUCH DETERMINATIONS

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AUTHORITY: 45 U.S.C. 355 and 362(1).

SOURCE: Board Order 58–142, 23 FR 9090, Nov. 22, 1958, unless otherwise noted.

§320.1 Introduction.

This part explains which units of the Board are authorized to make initial determinations with respect to entitlement to benefits under the Railroad Unemployment Insurance Act and waiver of recovery of overpayments under that Act. This part explains how notice of such determinations is to be communicated to the claimant and to his or her base-year employer(s) and how these determinations may be appealed.

[56 FR 65679, Dec. 18, 1991]

§320.2 Definitions.

As used in this part—

Base-year employer means the railroad employer(s) for whom a claimant worked and earned compensation creditable under the Railroad Unemployment Insurance Act during the base year. The base year is the calendar year immediately preceding the benefit year for which a claim is being filed. A benefit year is generally the period July 1 through the following June 30.

Party means the claimant, the base-year employer(s), or any person so designated under this part.

[56 FR 65679, Dec. 18, 1991]

§320.5 Initial determinations.

An initial determination shall be made with respect to each claim for unemployment or sickness benefits by the appropriate adjudicating office as provided by §320.6 of this part. Prior to making an initial determination the Board shall provide the claimant's base-year employer(s) and most recent employer if different with notice that a claim has been filed and that the employer(s) has an opportunity to submit information which may be pertinent to the adjudication of the claim. The adjudicating office shall make its determination on the basis of the claimant's application and claim and any relevant information or evidence including any information received from the base-year employer(s). A determination allowing payment of an initial claim shall not establish a presumption that benefits for subsequent claims in the same period of unemployment or sickness are also payable. The Director of Policy and Systems shall issue instructions with respect to the adjudication of claims and initial determination on such claims. If it is found that only part of the benefits claimed may initially be paid, a partial payment shall be made prior to a final decision on the whole claim.

[56 FR 65679, Dec. 18, 1991, as amended at 77156, Dec. 17, 2002]

§ 320.6 Adjudicating office.

(a) The term ''adjudicating office'' means any subordinate office of the Board which is authorized to make initial determinations and reconsideration decisions with respect to claims for benefits. The following paragraphs state which offices of the Board are adjudicating offices and define their authority to make determinations or decisions.

(b) *Field offices.* Field offices are authorized to make initial determinations on the following issues relating to eligibility for unemployment or sickness benefits, as the case may be:

(1) Availability for work;

(2) Voluntary leaving of work, with or without good cause;

(3) Failure to accept work or apply for work or failure to report to an employment office;

(4) Timely registration for unemployment benefits under § 325.2 of this chapter and timely filing of claims for sickness benefits under § 335.4(c) of this chapter;

(5) Receipt of remuneration for claimed days of unemployment or sickness, as the case may be;

(6) Mileage or work restrictions and stand-by or lay-over rules;

(7) Whether the claimant's unemployment is due to a strike.

(8) Whether a claimant's earnings attributable to days in a period for which he or she has registered for unemployment benefits exceed the amount of the applicable monthly compensation base.

(c) *Regional offices.* Board regional offices are authorized to make determinations on any of the issues listed in paragraph (b) of this section. In addition, regional offices are authorized to make initial determinations on the following issues:

(1) Erroneous payment of benefits, including fraud;

(2) Applicability of the disqualification in section 4(a–2)(iii) of the Railroad Unemployment Insurance Act if the claimant's unemployment results from a strike against a non-railroad employer by which he is employed;

(3) Determination of the amount of the Board's claim for reimbursement from pay for time lost payments under section 2(f) of the Railroad Unemployment Insurance Act or damages for personal injury under section 12(o) of the Railroad Unemployment Insurance Act.

(d) *Director of Operations.* The Director of Operations is authorized to make determinations on all issues of eligibility for unemployment and sickness benefits as set forth in paragraphs (b) and (c) of this section, and on any other issue not reserved to the Director of Policy and Systems by paragraph (e) of this section.

(e) *Director of Policy and Systems.* The Director of Policy and Systems shall adjudicate:

(1) The applicability of the disqualification in section 4(a–2)(iii) of the Railroad Unemployment Insurance Act if the claimant's unemployment results from a strike against a railroad employer by which he or she is employed; and

(2) Whether a plan submitted by an employer or other person or company qualifies as a nongovernmental plan for unemployment or sickness insurance, within the meaning of part 323 of this chapter.

(f) *Debt Recovery Manager.* The Debt Recovery Manager shall adjudicate:

(1) All requests for waiver of recovery of an erroneous payment made under the Railroad Unemployment Insurance Act; and

(2) Offers of compromise of debts arising out of the benefit provisions of the Railroad Unemployment Insurance Act.

[53 FR 2486, Jan. 28, 1988, as amended at 60 FR 28534, June 1, 1995; 67 FR 77156, Dec. 17, 2002]

§ 320.8 Notice of initial determination.

(a) *Benefits payable.* If benefits are payable for a claim, no special notice of the award will be issued to the claimant. A notice of the award will be sent to the base-year employer(s). The amount of benefits due will be certified to the United States Treasury Department for payment.

(b) *Benefits not payable.* If an initial determination results in denial of a claim, either in whole or in part, the adjudicating office shall issue a notice of the denial within 15 days of the date that it makes its determination. The notice shall explain the basis for the denial of benefits and shall set forth

what steps the claimant can take to contest the denial.

(c) *Communication of notice of denial.* When the adjudicating office mails the denial notice to the claimant's address of record, it shall be considered that notice of the denial has been communicated to the claimant on the date of mailing such notice. If the adjudicating office has been notified that a claimant has an attorney or other representative helping him or her with the claim, a copy of the denial notice shall be sent to the attorney or such other representative.

[53 FR 2486, Jan. 28, 1988, as amended at 56 FR 65679, Dec. 18, 1991]

§ 320.9 Notice of erroneous benefit payment.

(a) *Content of notice.* When an adjudicating office determines that benefits were paid erroneously, that office shall issue to the claimant a notice of the amount of the erroneous payment and the basis for the determination. The notice shall include a statement telling the claimant of his or her right to request reconsideration of the determination, of the provisions for waiver and of his or her right to request waiver.

(b) *Communication of notice of erroneous payment.* When the adjudicating office mails the erroneous payment notice to the claimant's address of record, it shall be considered that notice of the erroneous payment has been communicated to the claimant on the date of mailing such notice. If the adjudicating office has been notified that a claimant has an attorney or other representative helping him or her with the claim, a copy of the erroneous payment notice shall be sent to the attorney or such other representative.

[53 FR 2486, Jan. 28, 1988]

§ 320.10 Reconsideration of initial determination.

(a) *Request.* A claimant shall have the right to request reconsideration of an initial determination under § 320.5 of this part which denies in whole or in part his or her claim for benefits. A claimant shall have the right to request reconsideration of a notice of overpayment under § 320.9 of this part. The base-year employer(s) shall have the right to request reconsideration of an initial determination under § 320.5 of this part which awards in whole or in part a claimant's claim for benefits. A reconsideration request shall be made in writing and addressed to the adjudicating office that issued the initial determination and must be received by the adjudicating office no later than 60 days from the date of the notice of the initial decision. A railroad employer may fulfill the written request requirement by using an electronic system that has been approved by the agency in the manner prescribed by the agency.

(b) *Review of evidence.* Upon request, the party requesting reconsideration shall have an opportunity to review all evidence and documents that pertain to the initial determination. The Board shall made all reasonable efforts to protect the identity of the source of adverse evidence.

(c) *Notice of decision.* The adjudicating office shall, as soon as possible, render a decision on the request for reconsideration. If a decision rendered by a district office, as the adjudicating office, sustains the initial determination, either in whole or in part, the decision shall be referred to the appropriate regional office for review prior to issuance. The party who requested reconsideration shall be notified, in writing, of the decision on reconsideration no later than 15 days from the date of the decision or, where the regional office has conducted a review of the decision, within 7 days following the completion of the review. If the decision results in denial of benefits, the claimant shall be notified of the right to appeal as provided in § 320.12 of this part. If the decision results in payment of benefits, the base-year employer(s) shall be notified of the right to appeal as provided in § 320.12 of this part.

(d) *Right to further review of initial determination.* The right to further review of a determination made under § 320.5 or § 320.9 of this part shall be forfeited unless a written request for reconsideration is filed within the time period prescribed in this section or good cause is shown by the party requesting reconsideration for failing to file a timely request for reconsideration. A railroad

employer may fulfill the written request requirement by using an electronic system approved by the agency in the manner prescribed by the agency.

(e) *Timely request for reconsideration.* In determining whether either the claimant or the base-year employer(s) has good cause for failure to file a timely request for reconsideration, the adjudicating office shall consider the circumstances which kept either the claimant or the base-year employer(s) from filing the request on time and whether any action by the Board misled either of them. Examples of circumstances where good cause may exist include, but are not limited to:

(1) A serious illness which prevented the claimant from contacting the Board in person, in writing, or through a friend, relative or other person;

(2) A death or serious illness in the claimant's immediate family which prevented him or her from filing.

(3) The destruction of important and relevant records;

(4) A failure to be notified of a decision;

(5) The existence of an unusual or unavoidable circumstance which demonstrates that either the claimant or the base-year employer(s) would not have known of the need to file timely or which prevented either of them from filing in a timely manner; or

(6) The claimant thought that his or her representative had requested reconsideration.

[56 FR 65679, Dec. 18, 1991, as amended at 67 FR 77156, Dec. 17, 2002; 71 FR 53004, Sept. 8, 2006]

§ 320.11 Request for waiver of recovery.

(a) *Time limitation.* The claimant shall have 60 days from the date of the notification of the erroneous payment determination in which to file a request for waiver, except that where an erroneous payment is not subject to waiver in accordance with § 340.10(e) of this chapter, waiver may not be requested and recovery will not be stayed. Such requests shall be made in writing and be filed by mail or in person at any Board office. The claimant shall, along with the request, submit any evidence and argument which he or she would like to present in support of his or her case. A request solely for reconsideration of an overpayment shall not be considered a request for waiver under this section but shall be treated as a request for reconsideration under § 320.10 of this part.

(b) *Recovery action.* Where a claimant has made a timely request for waiver of recovery, no action will be taken to recover the erroneous payment by setoff against current benefits prior to a decision on such request; *provided however,* That the Board may, prior to a decision, withhold the amount of the erroneous payment from benefit payments under any of the following circumstances:

(1) The claimant admits he or she was at fault in causing the overpayment;

(2) The claimant is found to have committed fraud;

(3) The claimant authorizes recovery by setoff or agrees to repayment; or

(4) The amount of erroneous payment is not subject to waiver or provided for in § 340.10(e) of this chapter.

(c) *Review of evidence.* Upon request, the claimant shall have an opportunity to review all evidence and documents that pertain to the erroneous payment determination.

(d) *Decision.* The Debt Recovery Manager shall make a decision on the claimant's request for waiver of recovery and shall notify the claimant accordingly. The decision of the Manager shall include the basis of the decision, setting forth his or her reasons for the decision including the impact, if any, of any evidence submitted by the base-year or last employer. If the Manager decides that waiver of recovery is not appropriate, the adjudicating office shall wait 15 days from the date of the notification of the waiver decision before taking any action to recover the erroneous payment. If the Manager decides that recovery should be waived, any amount of the erroneous payment so waived but previously recovered by setoff shall be refunded to the claimant.

(e) *Appeal.* If the Debt Recovery Manager decides that waiver of recovery is not appropriate, the claimant shall have the right to appeal such decision as provided under § 320.12 of this part.

(f) *Requests made after 60 days.* Nothing in this section shall be taken to mean that waiver of recovery will not be considered in those cases where the request for waiver is not filed within 60 days, but action to recover the erroneous payment will not be deferred if such request is not filed within 60 days, and any amount of the erroneous payment recovered prior to the date on which the request is filed shall not be subject to waiver under part 340 of this chapter. Further, it shall not be considered that a claimant prejudices his or her request for waiver by tendering all or a portion of an erroneous payment or by selecting a particular method of repaying the debt. However, no waiver consideration shall be given to a debt which is settled by compromise.

(g) *Evidence provided by base-year employer(s) and most recent employer, if different.* In making a decision under paragraph (d) of this section, the Debt Recovery Manager shall consider all evidence of record including any evidence submitted by the claimant's base-year employer(s) and the most recent employer, if different. Where a claimant has requested waiver the Manager shall notify his or her base-year employer(s) and the most recent employer, if different, of the right to submit, within 30 days, any information which may be pertinent to the waiver decision.

[56 FR 65680, Dec. 18, 1991, as amended at 67 FR 77156, Dec. 17, 2002]

§ 320.12 Appeal to the Bureau of Hearings and Appeals.

(a) Any party aggrieved by a decision under § 320.10 of this part or a claimant aggrieved by a decision under § 320.11 of this part may appeal such decision to the Bureau of Hearings and Appeals. Such an appeal shall be made by filing the form prescribed by the Board for such purpose. The appeal must be filed with the Bureau of Hearings and Appeals within 60 days from the date upon which notice of the decision on reconsideration or waiver of recovery was mailed to either a claimant or the base year employer(s). Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's or base-year employer's right to appeal, *Provided that* the claimant or base-year employer files the appeal form within the later of the 60-day period from the date of the reconsideration decision, or the 30-day period following the date of the Board's letter sending the appeal form to the claimant or base-year employer.

(b) If no appeal is filed within the time limits specified in paragraph (a) of this section, the decision of the adjudicating office under §§ 320.10 or 320.11 of this part shall be considered final and no further review of such decision shall be available unless the hearings officer finds that there was good cause for the failure to file a timely appeal as described in § 320.10 of this part.

(c) Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the Bureau of Hearings and Appeals, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

[67 FR 77157, Dec. 17, 2002]

§ 320.18 Hearings officer.

Within a reasonable time after a party has filed a properly executed appeal, the Director of Hearings and Appeals shall appoint a hearings officer to act in the appeal. Such hearings officer shall not have any interest in the parties or in the outcome of the proceeding, shall not have directly participated in the initial determination from which the appeal is made, and shall not have any other interest in the matter which might prevent a fair and impartial hearing. In any case in which employee status or creditability of compensation is an issue, the hearings officer shall receive evidence and report to the Board thereon with recommendations. In all other cases, the hearings officer shall consider and decide the appeal; in each such case where the hearings officer determines that an issue of fact exists, the parties shall have the right to a hearing.

[56 FR 65680, Dec. 18, 1991]

§ 320.19 Election to participate.

(a) *Claimant files an appeal.* Where the claimant has filed an appeal under § 320.12 of this part the hearings officer shall notify the claimant's base-year employer(s) that such an appeal has been filed and shall provide the base-year employer with a statement of issues on appeal. The hearings officer shall inform the base-year employer(s) that such employer(s) shall have a right to be present at any hearing which is to be held under this part and the right to submit evidence with respect to the issues on appeal. Within 30 days of the date of such notice a base-year employer shall provide the hearings officer with a statement in writing which summarizes the evidence which such employer intends to present with respect to the issues on appeal, which indicates whether the employer wishes to be present at any hearing which may be held, and which designates who will represent the employer with respect to the appeal. An employer who fails to respond in the time prescribed shall be barred from further participation in the appeal and shall forfeit any further right to review as provided for in this part.

(b) *Base-year employer files an appeal.* Where a base-year employer files an appeal under § 320.12 of this part, the hearings officer shall notify the claimant that such an appeal has been filed and shall provide the claimant with a statement of issues on appeal. The hearings officer shall inform the claimant that he or she or a duly authorized representative shall have a right to be present at any hearing which is to be held under this part and the right to submit evidence with respect to the issues on appeal. Within 30 days of the date of such notice the claimant shall file with the hearings officer an election to participate in the appeal. A claimant who fails to file an election in the time prescribed shall be barred from further participation in the appeal and shall forfeit any right of review as provided for in this part.

[56 FR 65680, Dec. 18, 1991]

§ 320.20 Powers of hearings officer.

In the development of an appeal, the hearings officer shall have the power to hold hearings, require and compel the attendance of witnesses, administer oaths, take testimony, and make all necessary investigations.

§ 320.22 Notice of hearing.

(a) *Notification of parties.* At the discretion of the hearings officer, any hearing required under this part may be held in person, by telephone conference call, or by video teleconferencing as described in § 320.25(d). The hearings officer shall promptly notify the party or parties to the proceeding by mail as to said time and place for the hearing. The notice shall include a statement of the specific issues involved in the case. The hearings officer shall make every effort to hold the hearing within 150 days after the date the appeal is filed.

(b) *Notice of objection.* A party to the proceeding may object to the time and place of the hearing, or as to the stated issues to be resolved, by filing a written notice of objection with the hearings officer. The notice of objection shall clearly set forth the matter objected to and the reasons for such objection, and, if the matter objected to is the time and place of the hearing, said notice shall further state that party's choice as to the time and place for the hearing. Said notice of objection shall be filed at the earliest practicable time, but in no event shall said notice be filed later than five business days prior to the scheduled date of the hearing.

(c) *Ruling on objection.* The hearings officer shall rule on any objection timely filed by a party under this section and shall notify the party of his or her ruling thereon. The hearings officer may for good cause shown, or upon his or her own motion, reschedule the time and/or place of the hearing. If an individual objects to having a hearing by video teleconferencing, the hearings officer will find the individual's wish not to appear by video teleconferencing to be a good reason for changing the time or place of the scheduled hearing and will reschedule the hearing for a time or place where a telephone conference call or an in person hearing will be held. The hearings officer also may limit or expand the issues to be resolved at the hearing.

(d) *Failure to appear or to file objection.* If neither a party nor his or her representative appears at the time and place scheduled for the hearing, that party shall be deemed to have waived his or her right to an oral hearing unless said party either filed with the hearings officer a notice of objection showing good cause why the hearing should have been rescheduled, which notice was timely filed but not ruled upon, or, within 10 days following the date on which the hearing was scheduled, said party files with the hearings officer a motion to reschedule the hearing showing good cause why neither the party nor his or her representative appeared at the hearing and further showing good cause as to why said party failed to file at the prescribed time any notice of objection to the time and place of the hearing.

(e) *Rescheduling the hearing.* If the hearings officer finds either that a notice of objection was timely filed showing good cause to reschedule the hearing, or that the party has within 10 days following the date of the hearing filed a motion showing good cause for failure to appear and to file a notice of objection, the hearings officer shall reschedule the hearing. If the hearings officer finds that the hearing shall not be rescheduled, he or she shall so notify the party in writing.

[53 FR 2488, Jan. 28, 1988, as amended at 71 FR 55283, Sept. 22, 2006]

§ 320.25 Hearing of appeal.

(a) *Manner of conducting hearing.* The hearing shall be informal, fair, and impartial, and shall be conducted in such manner as to ascertain the substantial rights of the parties. The hearing shall not be open to the public.

(b) *Evidence presented in support of appeal.* (1) Any party, or his or her representative, shall be afforded full opportunity to present evidence upon any controversial question of fact, orally or in writing or by means of exhibits; to examine and cross-examine witnesses; and to present argument in support of the appeal.

(2) The formal rules of evidence shall not apply; however, the hearings officer may exclude evidence which he or she finds is irrelevant or repetitious. Any evidence excluded by the hearings officer shall be described and that description made part of the record.

(3) If, in the judgment of the hearings officer, evidence not offered is available and is relevant and material to the merits of the claim, the hearings officer may obtain such evidence upon his or her own initiative. If new evidence is obtained after an oral hearing, other than evidence submitted by a party or his representative, the hearings officer shall provide the parties or their representatives with a copy of such evidence. In such event, any party shall have 30 days to submit rebuttal evidence or argument or to request a supplemental hearing to confront and challenge such new evidence. Any party may move for an extension of time to submit rebuttal evidence or argument and the hearings officer may grant the motion upon a showing of good cause.

(c) *Where no oral hearing required.* Where the hearings officer finds that no factual issues are presented by an appeal, and the only issues raised by the parties are issues concerning the application or interpretation of law, the parties or their representatives shall be afforded full opportunity to submit written argument in support of their position but no oral hearing shall be held.

(d) *Hearing by telephone or video teleconferencing.* As stated in § 320.22(a), at the discretion of the hearings officer, any hearing required under this part may be conducted in person, by telephone conference call, or by video teleconferencing. The hearings officer may determine the hearing should be conducted by telephone conference call or video teleconferencing if use of these methods would be more efficient than conducting an in person hearing and the hearings officer does not determine that there is a circumstance in the particular case preventing the use of these methodologies to conduct the hearing.

[Board Order 58–142, 23 FR 9090, Nov. 22, 1958, as amended at 56 FR 65681, Dec. 18, 1991; 67 FR 77157, Dec. 17, 2002; 71 FR 55284, Sept. 22, 2006]

§ 320.28 Record of evidence considered.

The hearings officer will make a record of the material evidence. The

record will include the applications, written statements, reports, and other documents that were used in making the determination under review and any other additional evidence the appellant or any other party to the hearing presents in writing. If a hearing was held in the appeal, the tape recording of the hearing will be part of the record while the appeal is pending. The hearings officer's decision will be based on the record. The entire record at any time during the pendency of the appeal shall be available for examination by any party or by his or her duly authorized representative.

[67 FR 77157, Dec. 17, 2002]

§ 320.30 Decision or report of hearings officer.

As soon as practicable after the completion of the record, the hearings officer shall render his decision, or submit his report to the Board, as may be appropriate in the case. The decision or report shall be based on the record and shall be in writing. Such decision shall contain a brief statement of (a) the issue or issues raised, (b) the evidence submitted, (c) findings of fact, (d) the decision made, and (e) the reasons therefor. Such report shall contain a statement of (1) the issue or issues raised, (2) the evidence submitted, (3) findings of fact, (4) conclusions of law, (5) recommendations as to the decision to be made by the Board, and (6) such discussion of the foregoing as the hearings officer may desire to present to the Board. Within 15 days after rendition of the decision or submission of the report, a copy of the decision or report shall be mailed to each party at the last address of record. In the case of a report, a copy of the transcript of the hearing, if any was held, shall also be mailed to each party.

[Board Order 66–84, 31 FR 10181, July 28, 1966, as amended at 56 FR 65681, Dec. 18, 1991]

§ 320.32 Effect of decision of hearings officer.

A decision of the hearings officer, subject to review as hereinafter provided, shall be binding upon any adjudicating office and upon all parties;

(a) With respect to the initial determination involved, and

(b) With respect to other initial determinations, irrespective of whether they have been appealed, which involved the same parties and which were based upon the same issue or issues determined in the decision of the hearings officer.

[56 FR 65681, Dec. 18, 1991]

§ 320.35 Review of decision of hearings officer on motion of Board.

The Board may, on its own motion, review a decision of the hearings officer on the basis of the evidence previously submitted in the case, and may designate any employee of the Board to take additional evidence and to report his findings to the Board.

§ 320.38 Appeal to Board from decision of hearings officer.

Any claimant aggrieved by a decision of the hearings officer and any base-year employer(s) whose employee was awarded benefits, who participated in the appeal before the hearings officer, may appeal to the Board for review of the decision.

[56 FR 65681, Dec. 18, 1991]

§ 320.39 Execution and filing of appeal to Board from decision of hearings officer.

(a) An appeal to the Board from the decision of a hearings officer shall be filed on the form provided by the Board and shall be executed in accordance with the instructions on the form. Such appeal shall be filed within 60 days from the date upon which notice of the decision of the hearings officer was mailed to the parties. The right to further review of a decision of a hearings officer shall be forfeited unless formal final appeal is filed in the manner and within the time prescribed in this section. Any written request stating an intent to appeal which is received within the 60-day period will protect the claimant's right to appeal, *Provided that* the claimant files the appeal form within the later of the 60-day period following the date of the hearing officer's decision, or the 30-day period following the date of the letter sending the appeal form to the claimant. However, when a party fails to file an appeal before the Board within the time

prescribed in this section, the Board may waive this requirement if along with the final appeal, the party in writing requests an extension of time. The request for an extension of time must give the reasons why the final appeal form was not filed within the time limit prescribed in this section. If in the judgment of the Board the reasons given establish that the party has good cause for not filing the final appeal form within the time limit prescribed, the Board will consider the appeal to have been filed in a timely manner. The Board will use the standards found in § 320.10(e) of this part in determining if good cause exists.

(b) Where a timely appeal seeking waiver of recovery of an erroneous payment has been filed with the three-member Board, the Board shall not commence recovery of the erroneous payment by suspension or reduction of a monthly benefit payable by the Board until a decision with respect to such appeal seeking waiver has been made and notice thereof has been mailed to the claimant.

[67 FR 77157, Dec. 17, 2002; 68 FR 6820, Feb. 11, 2003]

§ 320.40 Procedure before the Board on appeal from a decision of a hearings officer.

Upon the filing of an appeal to the Board from a decision of a hearings officer, the Secretary to the Board shall notify all parties to the decision of the hearings officer that an appeal has been filed. The parties shall not have the right to submit additional evidence, except that:

(a) The Board may permit the submission of additional evidence upon a showing by a party that he or she has additional evidence to present which, for valid reasons, he or she was unable to present at an earlier stage;

(b) The Board may request the submission of additional evidence; and

(c) The Board may designate any employee of the Board to take additional evidence and to report his or her findings to the Board. Any such additional evidence shall be submitted in such manner as the Board may indicate and shall be included in the record.

(d) Any party may submit additional argument in writing with the appeal to the Board. No party shall have the right to an oral presentation before the Board except where the Board so permits. Such presentation may be limited in form, subject matter, length, and time as the Board may indicate to the parties.

[56 FR 65681, Dec. 18, 1991, as amended at 67 FR 77158, Dec. 17, 2002]

§ 320.41 Procedure before Board after submission of report by hearings officer.

(a) After submission to the Board of a hearings officer's report, in an appeal involving employee status or the creditability of compensation, any party to the proceeding may, within twenty days after the mailing to him of a copy of the report, file with the Board and serve upon other parties by mailing to their last addresses of record such exceptions in writing as he desires to make to the hearings officer's findings of fact and conclusions of law. Each exception shall specifically designate the particular finding of fact or conclusion of law to which exception is taken, and shall set forth in detail the grounds of the exception. General exceptions and exceptions not specifically directed to particular findings of fact or conclusions of law will not be considered. Each party shall have ten days after the receipt of exceptions taken by other parties in which to file with the Board replies to the exceptions. The Board may, upon the application of any party and for cause shown, extend the time for filing and serving of exceptions or filing of replies thereto. The hearings officer's report shall be advisory but shall be presumed to be correct. Findings of fact to which no exceptions are taken will, subject only to the power of the Board to reject or modify, stand confirmed.

(b) Further argument will not be permitted except upon a showing by any party that he has arguments to present which for valid reasons he was unable to present at an earlier stage, and in cases in which the Board requests further elaboration of arguments. In such cases, the further argument shall be submitted orally or in writing, as the Board may indicate in each case, and shall be subject to such restrictions as

to form, subject matter, length, and time as the Board may indicate.

§ 320.42 Decision of Board.

The decision of the Board, whether on an appeal to the Board from a decision of a hearings officer, or after submission of a report by a hearings officer, shall be made upon the basis of the record established in accordance with the foregoing sections. Notice of such decision, together with the Board's findings of fact and conclusions of law in connection therewith, shall, within 15 days from the date on which the decision is made, be mailed to the parties at the latest addresses furnished by them. Subject only to judicial review in accordance with § 320.45, the decision of the Board shall be final and conclusive for all purposes:

(a) With respect to the initial determination involved, and

(b) With respect to other initial determinations, irrespective of whether they have been appealed, which involve the same parties and which were based on the same issue or issues determined in the decision of the Board. In a case in which there has been a hearings officer's report, in an appeal involving employee status or the creditability of compensation, the decision of the Board on all issues determined in such decision shall be final and conclusively establish all rights and obligations, arising under the Act, of every party notified as hereinabove provided of his or her right to participate in the proceedings.

[Board Order 66–84, 31 FR 10181, July 28, 1966, as amended at 56 FR 65681, Dec. 18, 1991]

§ 320.45 Judicial review.

Upon being notified of a decision of the Board made (a) upon review, on the Board's own motion, of a decision of a hearings officer, or (b) upon an appeal to the Board, an aggrieved party may obtain judicial review of such final decision, by filing a petition for review within ninety days after the date on which notice of such decision was mailed to him, or within such further time as the Board may allow, in the U.S. Court of Appeals for the circuit in which the party resides or will have had his principal place of business or principal executive office, or in the U.S. Court of Appeals for the Seventh Circuit or in the Court of Appeals for the District of Columbia.

[Board Order 58–142, 23 FR 9090, Nov. 22, 1958, as amended at 56 FR 65682, Dec. 18, 1991]

§ 320.48 Representatives of parties.

In the event a party to any proceeding within the Board, under the preceding regulations in this part, desires to be represented by another person, he shall file with the Board prior to the time of such representation a power of attorney signed by him and naming such other person as the person authorized to represent him: *Provided, however*, That without requiring such power of attorney the Board may recognize as the duly authorized representative of the claimant the person designated by the claimant's railway labor organization to act in behalf of members of that organization on such matters whenever such representative acts or appears for such claimant.

§ 320.49 Determination of date of filing.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section, for purposes of this part, a document or form is filed on the day it is received by an office of the Board or by an employee of the Board who is authorized to receive it at a place other than one of the Board's offices.

(b) *Other dates of filing.* The Board will also accept as the date of filing the date a document or form is mailed to the Board by the United States mail, if using the date the Board receives it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, the Board will consider other evidence of when the document or form was mailed to the Board.

(c) *Use of electronic mail.* By agreement between a base-year employer and the Board, any document required to be filed with the Board or any notice required to be sent to the employer may be transmitted by electronic mail.

[67 FR 77158, Dec. 17, 2002]

PART 321—ELECTRONIC FILING OF APPLICATIONS AND CLAIMS FOR BENEFITS UNDER THE RAILROAD UNEMPLOYMENT INSURANCE ACT

Sec.
321.1 Filing applications electronically.
321.2 Filing claims for benefits electronically.

AUTHORITY: 45 U.S.C. 355 and 362(l).

SOURCE: 69 FR 32260, June 9, 2004, unless otherwise noted.

§ 321.1 Filing applications electronically.

(a) *Electronic filing.* An application for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Internet Web site, *http://www.rrb.gov,* utilizing a User ID and a PIN/Password.

(b) *Adjudication of applications filed electronically.* An application filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for an application filed electronically shall be the date that the electronic filing of the application is accepted by the Board's electronic system. If an attempt to file an application through the Board's electronic system is unsuccessful and is rejected by that system, the claimant must submit another application. If the subsequent application, filed either electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing attempt was rejected, the Board will establish the filing date of the subsequent application as the date the rejected application was attempted to be filed.

§ 321.2 Filing claims for benefits electronically.

(a) *Electronic filing.* A claim for benefits under the Railroad Unemployment Insurance Act may be filed electronically through the Board's Internet Web site, *http://www.rrb.gov,* utilizing a User ID and a PIN/Password.

(b) *Adjudication of claims filed electronically.* A claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be adjudicated in accordance with the procedures set forth in this part.

(c) *Date of filing.* The date of filing for a claim for benefits under the Railroad Unemployment Insurance Act filed electronically shall be the date that the electronic filing of the claim is accepted by the Board's electronic system. If an attempt to file a claim for benefits under the Railroad Unemployment Insurance Act is unsuccessful and is rejected by the Board's electronic system, the claimant must submit another claim for benefits. If the subsequent claim for benefits, either filed electronically or on paper, is received by the Board within 30 days from the date of the notification that the initial filing was rejected, the Board will establish the filing date of the subsequent claim as the date the rejected claim was attempted to be filed.

PART 322—REMUNERATION

Sec.
322.1 Introduction.
322.2 General definition of remuneration.
322.3 Determining the days with respect to which remuneration is payable or accrues.
322.4 Consideration of evidence.
322.5 Payments under vacation agreements.
322.6 Pay for time lost.
322.7 Dismissal, coordination, and separation allowances.
322.8 Miscellaneous income.
322.9 Subsidiary remuneration.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 59–73, 24 FR 2487, Mar. 31, 1959, unless otherwise noted.

§ 322.1 Introduction.

The Railroad Unemployment Insurance Act provides benefits for a qualified employee's days of unemployment or days of sickness, as defined in section 1(k) of the Act. Under that section, no day can be a day of unemployment or a day of sickness for any employee if ''remuneration'' is payable or accrues to the employee for such day. In computing the amount of benefits payable to an employee for days of unemployment or days of sickness in any registration period, or in determining whether the employee has satisfied the waiting period requirement, the Board will not count any day with respect to

which remuneration is payable or accrues to the employee. Section 322.2 defines the term ''remuneration'' and explains what types of payments to employees constitute remuneration.

[65 FR 14459, Mar. 17, 2000]

§ 322.2 General definition of remuneration.

(a) *Remuneration.* (1) Remuneration includes pay for services for hire, pay for time lost as defined in § 322.6, and other earned income payable or accruing with respect to any day. Income is ''earned'' if it is payable or accrues in consideration of services and if such services were in turn rendered in consideration of the income payable or accruing.

(2) Remuneration includes income in the form of a commodity, service, or privilege if, before the performance of the service for which it is payment, the parties have agreed upon the value of such commodity, service, or privilege, and that such part of the amount agreed upon to be paid may be paid in the form of such commodity, service, or privilege.

(3) Remuneration for a working day that includes a part of two consecutive calendar days is deemed to have been earned on the first of such two days.

(b) *Subsidiary remuneration.* For the purpose of this part, remuneration does not include subsidiary remuneration, as defined in § 322.9. Subsidiary remuneration for any day does not prevent such day from being a day of unemployment or a day of sickness, except as explained in § 322.9.

(c) *Supplemental unemployment or sickness benefits.* The term remuneration does not include money payments received by an employee pursuant to any nongovernmental plan for unemployment or sickness insurance, as defined in part 323 of this chapter. Employer payments of sick pay to an employee are remuneration, except when payment is made pursuant to a nongovernmental plan for sickness insurance.

[65 FR 14459, Mar. 17, 2000]

§ 322.3 Determining the days with respect to which remuneration is payable or accrues.

(a) *Payable or accrues.* In determining whether remuneration is ''payable'' or ''accrues'' to an employee with respect to a claimed day or days, consideration shall be given to such factors as

(1) The intention of the parties with respect to the remuneration as indicated in employment contracts, in any expressed or implied agreements between the parties, and by the actions of the parties;

(2) Any evidence, such as vouchers or agreement of the parties, relating the remuneration to a particular period of time or indicating that the remuneration accrued or became payable without reference to any particular period of time;

(3) The measure by which the amount of remuneration was determined;

(4) Whether the amount of the remuneration is proportionate to the length of time needed to render the service for which it is payment;

(5) Whether the service for which the remuneration accrues is required to be rendered on any particular day or particular days; and

(6) Whether a specified amount of the remuneration is contingent upon a result accomplished on a particular day or particular days.

(b) *Layover days.* Remuneration shall not be regarded as payable or accruing to an employee with respect to his or her ''layover'' days between regular assignments in train and engine service solely because they are termed ''layover'' days. But no such ''layover'' day may be considered as a day of unemployment or sickness. See § 332.6 of this chapter.

(c) *Guaranteed earnings.* A payment under a plan which guarantees an amount of earnings or mileage in a specified period is remuneration with respect to each day in the specified period.

(d) *Equivalent of full-time work.* An employee who works fewer than five days each week under a compressed work schedule that provides the equivalent of full-time employment does not earn remuneration with respect to his or her additional rest days resulting

from such work schedule, but such employee will not be considered to be available for work on such rest days. See § 327.10(d) of this chapter.

[Board Order 59–73, 24 FR 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.4 Consideration of evidence.

(a) *Initial proof.* A claimant's certification that he or she did not work on any day claimed and did not receive income such as vacation pay or pay for time lost for any such day shall constitute sufficient evidence for an initial finding that no remuneration is payable or has accrued to him or her with respect to such day, unless a base year employer reports that he or she worked on days claimed or received payments that constitute remuneration as defined in this part, or unless there is other conflicting evidence.

(b) *Investigation.* When there is a question as to whether or not remuneration is payable or has accrued to a claimant with respect to a claimed day or days, investigation shall be made with a view to obtaining information sufficient for a finding.

(Approved by the Office of Management and Budget under control number 3220–0049)

[Board Order 59–73, 24, 2487, Mar. 31, 1959, as amended at 52 FR 11017, Apr. 6, 1987; 65 FR 14460, Mar. 17, 2000]

§ 322.5 Payments under vacation agreements.

(a) *General.* In ascertaining the accrual of remuneration under a vacation agreement, consideration shall be given to the applicable agreements and practices, the interpretations of such agreements and practices developed by the parties, and the actions of the parties pursuant thereto. When there is information that an employee has received or is to receive payment under a vacation agreement, such payment shall, in the absence of evidence to the contrary, be considered to be remuneration with respect to the days to which the payment is assigned.

(b) *Vacation pay.* If an employee takes a vacation in accordance with a vacation agreement, the payment for such vacation shall constitute remuneration with respect to the days in the vacation period for which the payment is made. An employee shall be regarded as taking a vacation when, in accordance with the applicable agreements and practices (1) he is absent from work during a scheduled or assigned vacation period; (2) he is required to take his vacation with pay while he is on furlough; or (3) he chooses to take his vacation with pay while he is unemployed or absent from work due to illness or other personal circumstances.

(c) *Pay in lieu of vacation.* If a payment in lieu of vacation is made to an employee under a vacation agreement such payment shall not constitute remuneration with respect to any particular day or days. A payment under a vacation agreement shall be regarded as in lieu of vacation if:

(1) The payment is made at the end of the vacation year to an employee who did not take his vacation during such year; or

(2) The payment is made after the employee's death, or after he ceased service for the purpose of receiving an annuity, and the payment is credited to the employee's last day of service; or

(3) It is otherwise established that the parties intended the payment to be in lieu of vacation, without reference to any particular period.

[Board Order 59–73, 24, 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.6 Pay for time lost.

(a) *Definition.* The term ''pay for time lost'' means any payment made to an employee with respect to an identifiable period of time during which the employee was absent from the active service of the person or company making the payment, including absence on account of personal injury. The entire amount paid to an employee who was absent on account of personal injury is pay for time lost if such amount includes pay for time lost, unless at the time of payment the parties, by agreement, specify a different amount as the amount of the pay for time lost and the period of time covered by such pay. The amount allocated to time lost is remuneration for every day in the period of time lost. The amount of a payment for personal injury that is apportioned to factors other than time lost

is, nevertheless, a portion of ''damages'' for the purposes of part 341 of this chapter.

(b) *Employment relationship required.* Pay for time lost shall not be deemed to have been earned on any day after the day of the employee's resignation or other termination of his employment relationship.

(c) *Initial evidence.* A report that an employee has received or is to receive pay for time lost shall, in the absence of evidence to the contrary, be considered sufficient for a finding that remuneration is payable with respect to each day in the period to which the pay is assigned.

[Board Order 59–73, 24, 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.7 Dismissal, coordination, and separation allowances.

(a) *Coordination or dismissal allowance.* Coordination or dismissal allowances are payments made to an employee who has been furloughed for a specified period of time during which he or she continues in an employment relationship and remains subject to call. Such pay is remuneration with respect to each day in the month or other period for which it is payable. The employer shall be held liable to the Board for any benefits paid to the employee and found recoverable under section 2(f) of the Railroad Unemployment Insurance Act by reason of the payment of any such allowances or other pay for the same days for which the Board paid benefits.

(b) *Separation allowance.* A separation allowance or severance payment made to an employee who voluntarily or involuntarily terminates his or her employment relationship is not remuneration with respect to any day after the employment relationship is severed. An employee who is paid a separation allowance, whether in a lump sum or in installments, is disqualified by section 4(a–1)(iii) of the Railroad Unemployment Insurance Act from receiving unemployment or sickness benefits for the period of time approximating the length of time it would have taken the employee to earn, at his or her ''straight'' time rate of pay, the amount of the separation allowance if he or she had continued working in the job from which he or she separated.

[65 FR 14460, Mar. 17, 2000]

§ 322.8 Miscellaneous income.

(a) *Income from self-employment.* In determining whether income from self-employment is remuneration with respect to a particular day or particular days, consideration shall be given to whether, and to what extent, (1) such income can be related to services performed on the day or days and (2) the expenses of the self-employment can be attributed to the day or days. Income from services performed by an individual on a farm which he owns or rents, or in his own mercantile establishment, ordinarily is not remuneration with respect to any day.

(b) *Income from investment.* Income in the form of interest, dividends, and other returns on invested capital which is not coupled with the rendition of personal services shall not be regarded as remuneration.

(c) *Commissions on sales.* Commissions on sales shall be regarded as remuneration with respect to the day or days on which sales are made.

(d) *Payments for service as a public official.* In determining whether income for service as a public official is remuneration and, if so, the particular day or days with respect to which such remuneration is payable or accrues, consideration shall be given to such factors as (1) the amount of the income; (2) the terms and conditions of payment; (3) the character and extent of the services rendered; (4) the importance, prestige, and responsibilities attached to the position; (5) the day or days on which services, or readiness to perform services, are required; and (6) the provisions of the applicable statutes.

(e) *Payments to local lodge officials.* A payment by a local lodge of a labor organization to an employee for services as a local lodge official shall be regarded as subsidiary remuneration if such payment does not exceed an average of $15 a day for the period with respect to which it is payable or accrues, unless there is information that the work from which the payment is derived does not require substantially less than full time as determined by generally prevailing standards, or is

not susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another occupation.

(f) *Public relief payments.* Public relief payments made in consideration of need shall not be regarded as remuneration.

[Board Order 59–73, 24, 2487, Mar. 31, 1959, as amended at 65 FR 14460, Mar. 17, 2000]

§ 322.9 Subsidiary remuneration.

(a) *Definition.*The term ''subsidiary remuneration'' means remuneration not in excess of an average of $15 per day for the period with respect to which it is payable or accrues, if

(1) The work from which the remuneration derives requires substantially less than full time as determined by generally prevailing standards; and

(2) The work is susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another occupation.

(b) *Exception.* If a claimant's remuneration is ''compensation'' as defined in part 302 of this chapter, such remuneration is not subsidiary unless the claimant had base year compensation from a different position or occupation of not less than two and one-half times the monthly compensation base for months in the base year in which he or she received the remuneration. Compensation in excess of an average of $15 per day is remuneration for the days for which it is payable or accrues.

(c) *Period for which remuneration is payable or accrues.* The ''period'' of time used in determining whether remuneration averages more than $15 per day depends on the terms and conditions of the employment and the rate of payment for the work. If the claimant is paid a monthly salary, the ''month'' is the period with respect to which the pay must average not more than $15 per day. The average is the monthly salary divided by 30. If the claimant is paid a weekly salary, the amount of the salary is divided by seven. If the claimant is paid by the hour or the day, the ''period'' is the day. Where payment is made by the hour or the day, the pay is not added up and then averaged out over the week or the month. For example, earnings of $20 on one day and $10 on another day do not average out to $15 per day so as to permit both days to be considered as days of unemployment or days of sickness.

(d) *Substantially less than full time.* The phrase ''substantially less than full time'' means employment of not more than four hours per day.

(e) *Compatibility with full time employment.* Work is considered to be susceptible of performance at such times and under such circumstances as not to be inconsistent with the holding of normal full-time employment in another position or occupation if it is a form of secondary employment that a claimant has done or could do at his or her own convenience while performing the duties of his or her railroad job.

(f) *Determinations.* The Board shall make a determination whether remuneration is subsidiary by applying the standards in this section to the facts of each case. Earnings that average more than $15 per day are not subsidiary remuneration under any circumstances. Also, earnings of any amount that are included in a claimant's qualifying base year compensation are not subsidiary remuneration. Even if earnings do not exceed an average of $15 per day, they may still not be subsidiary remuneration if the claimant worked more than four hours per day or if the work had to be performed at such times and under such circumstances as to be inconsistent with the holding of normal full-time work in his or her regular railroad work. If the evidence does not establish that the earnings are subsidiary remuneration, the question whether they are remuneration for particular days will then be considered.

(g) *Examples.* The following examples illustrate this section.

(1) A claimant receives a salary of $350 per month for serving as secretary-treasurer of the local lodge of his union. He performs a variety of duties at his own convenience while holding down a full-time railroad job in his craft. The average payment per day is not more than $15 and is, therefore, subsidiary remuneration.

(2) A claimant worked three hours per day, at $5 per hour, in the family insurance business. He was marked up for work as an extra board trainman

and worked whenever he was called. When called, he skipped work in the family insurance business. His insurance earnings of $15 per day were subsidiary remuneration.

(3) While unemployed from her railroad job, a claimant took a job as a school bus driver. She worked from 7 a.m. to 9 a.m., and 2:30 p.m. to 5:30 p.m. Her regular railroad job was a daytime job from 8 a.m. to 4:30 p.m. Her pay as a school bus driver was not subsidiary remuneration because the job was not compatible with the holding of full time work in her regular railroad occupation.

[65 FR 14460, Mar. 17, 2000]

PART 323—NONGOVERNMENTAL PLANS FOR UNEMPLOYMENT OR SICKNESS INSURANCE

Sec.
323.1 Introduction.
323.2 Definition of nongovernmental plan for unemployment or sickness insurance.
323.3 Standards for Board approval of a nongovernmental plan.
323.4 Guidelines for content of a nongovernmental plan.
323.5 Submitting proposed plan for Board approval.
323.6 Treatment of benefit payments under a nongovernmental plan for purposes of contributions.
323.7 Effective date.

AUTHORITY: 45 U.S.C. 362(1).

SOURCE: 56 FR 26328, June 7, 1991, unless otherwise noted.

§ 323.1 Introduction.

(a) This part defines the phrase *nongovernmental plan for unemployment or sickness insurance* and sets forth the procedure by which an employer may obtain a determination by the Railroad Retirement Board as to whether a particular plan that such employer maintains for its employees qualifies as a nongovernmental plan. In general, any payment by an employer to an employee for services rendered as an employee will be considered to be *remuneration* within the meaning of section 1(j) of the Railroad Unemployment Insurance Act and part 322 of this chapter. This includes employer payments that relate to an employee's loss of earnings during a period of time when the employee is unemployed or sick, including sickness resulting from injury. The exception is when an employer pays an employee a benefit pursuant to the provisions of a nongovernmental plan for unemployment or sickness insurance established by an employer for the benefit of its employees. Benefit payments under such plans are not remuneration and do not affect an employee's eligibility for unemployment or sickness benefits under the Railroad Unemployment Insurance Act.

(b) This part does not have any general applicability to private insurance contracts under which an insurance company, pursuant to a policy of insurance maintained by or for an employee, pays medical or hospital expenses or other cash benefits to or in behalf of an employee. Nor does this part apply to any private plan for relief of unemployment established by a party other than an employer such as, for example, a plan established by a labor union under which it undertakes to pay benefits to striking members of the union out of a strike insurance fund. Insurance policy benefits and strike unemployment benefits, although paid under plans that are nongovernmental in nature, are not considered remuneration for services under the general definition of *remuneration*. See part 322 of this chapter.

§ 323.2 Definition of nongovernmental plan for unemployment or sickness insurance.

A nongovernmental plan for unemployment or sickness insurance is a benefit plan, program or policy that is in the nature of insurance and is designed and established by an employer for the purpose of supplementing the benefits that an employee of such employer may receive under the Railroad Unemployment Insurance Act during a period of unemployment or sickness. A nongovernmental plan may be established by labor-management agreement or by unilateral employer action. Payments under such plans are referred to as supplemental unemployment benefits (SUB pay) or supplemental sickness benefits, rather than as wages, salary or pay for time lost, because their inherent nature is to supplement benefit payments under the Railroad

Unemployment Insurance Act rather than to replace or duplicate such payments.

§ 323.3 Standards for Board approval of a nongovernmental plan.

An unemployment or sickness benefit plan qualifies as a nongovernmental plan if it conforms to the following standards:

(a) The plan is in writing and has been published or otherwise communicated to covered employees prior to the inception of the plan;

(b) Benefits under the plan are payable only to employees who are involuntarily laid off or separated from the service of the employer or who are absent from work on account of illness or injury;

(c) Payment of benefits under the plan is conditioned upon a covered employee's meeting the eligibility conditions governing payment of benefits under the Railroad Unemployment Insurance Act. However, a plan will not be disqualified merely because it:

(1) Provides benefits during any waiting period required under the Railroad Unemployment Insurance Act, or

(2) Provides benefits after an employee has exhausted rights to benefits under the Railroad Unemployment Insurance Act, or

(3) Provides benefits during a period when the employee is not a ''qualified employee'', within the meaning of part 302 of this chapter;

(d) Payment of benefits under the plan is coordinated with benefit payments to which the employee may be entitled under the Railroad Unemployment Insurance Act. In general, plan benefit payments will be considered coordinated with Railroad Unemployment Insurance Act benefit payments when computation of the plan benefits takes Railroad Unemployment Insurance Act benefit entitlement into consideration in such a way as to make it clear that the plan is supplementing Railroad Unemployment Insurance Act benefit payments for days of unemployment or days of sickness. For example, a plan that provides for payment of a specified daily benefit amount is considered coordinated with Railroad Unemployment Insurance Act benefit payments if the plan provides that the daily benefit amount otherwise payable to the employee is reduced by the amount of benefits that the employee received or could receive under the Railroad Unemployment Insurance Act for the same day if the employee had met all the eligibility criteria for such benefit. Similarly, there is acceptable coordination if the plan simply provides for payment of an amount as an ''add-on'' benefit to the amount of Railroad Unemployment Insurance Act benefits paid or payable. On the other hand, a plan that allows payment so as to compensate an employee for railroad or non-railroad earnings that are lower in amount than what the employee would get under the plan if he or she were not employed is not considered coordinated with benefit payments under the Railroad Unemployment Insurance Act because an employer payment made under such circumstances supplements earnings rather than benefit payments under the Railroad Unemployment Insurance Act. No Railroad Unemployment Insurance Act benefits are payable to an employee who is earning remuneration from railroad or non-railroad employment. Employer payments that make up for low earnings are pay for time lost and therefore are *compensation* and *remuneration*;

(e) The plan confers upon covered employees an enforceable right to the benefits under the plan. The plan may not commit to management discretion any decision as to whether such employee will actually be paid the benefits to which he is entitled under the plan or the amount to be paid;

(f) The plan may not provide benefits to a covered employee in an amount that, when added to his or her Railroad Unemployment Insurance Act benefits, is greater than the wages of salary that would have been paid if the employee were employed; and

(g) The plan incorporates the features set forth in § 323.4 of this part and has been approved by the Board's Director of Unemployment and Sickness Insurance as a nongovernmental plan for unemployment or sickness insurance.

§ 323.4 Guidelines for content of a nongovernmental plan.

At a minimum, a nongovernmental plan for unemployment or sickness insurance should contain the following features:

(a) The title of the plan (e.g., Supplemental Unemployment Benefit Plan or Supplemental Sickness Benefit Plan);

(b) A statement of purpose, such as the following:

> There is hereby established a nongovernmental plan for (unemployment insurance) (sickness insurance) [specify which one] within the meaning of section 1(j) of the Railroad Unemployment Insurance Act. The purpose of this plan is to supplement the benefits that an eligible employee may receive under that Act and not to replace or duplicate such benefits. Payments under this plan are designed as one of the benefits of employment with [name of employer] and are not intended as pay for time lost or any other form of remuneration for services rendered as an employee;

(c) A statement as to which class or craft of employees, or other specified group of employees, is covered by the plan;

(d) The criteria governing a particular covered employee's eligibility for supplemental benefits under the plan;

(e) The dollar amount of supplemental benefits payable on a periodic basis to an eligible employee, the duration of supplemental benefits, how such benefits will be computed, and the conditions under which an employee will be disqualified or benefit payments reduced or terminated; and

(f) The identity of the plan administrator and the procedure by which a covered employee may claim supplemental benefits under the plan, including forms to be filed (if any), how to file, the time limit for filing, and how an employee may appeal from a denial of supplemental benefits.

§ 323.5 Submitting proposed plan for Board approval.

An employer shall submit each proposed plan, or a proposed revision to an existing plan, to the Director of Unemployment and Sickness Insurance, Railroad Retirement Board, 844 Rush Street, Chicago, Illinois 60611. The Director shall determine whether the plan or revision conforms to this part. Approval shall be effective as of the effective date of the plan. If not approved, the Director will advise the employer in which particular respects the proposed plan or revision does not conform to this part.

§ 323.6 Treatment of benefit payments under a nongovernmental plan for purposes of contributions.

Benefit payments under nongovernmental plans approved by the Board under this part are not *compensation* as defined in section 1(i) of the Railroad Unemployment Insurance Act, and therefore they are not subject to contribution under part 345 of this chapter.

§ 323.7 Effective date.

(a) This part shall not apply to a plan approved by the Director of Unemployment and Sickness Insurance prior to the effective date of this part. However, it shall apply to any proposed revision to such plan.

(b) Any plan in effect on the effective date of this part that has not been approved by the Director of Unemployment and Sickness Insurance shall be considered a proposed plan for purposes of § 323.5.

PART 325—REGISTRATION FOR RAILROAD UNEMPLOYMENT BENEFITS

Sec.

325.1 General.
325.2 Procedure for registering for unemployment benefits.
325.3 Application for unemployment benefits and employment service.
325.4 Claim for unemployment benefits.
325.5 Death of employee.
325.6 Verification procedures.

AUTHORITY: 45 U.S.C. 362(i) and 362(l).

SOURCE: 54 FR 24551, June 8, 1989, unless otherwise noted.

§ 325.1 General.

(a) *Day of unemployment.* A ''day of unemployment'' is a calendar day on which an employee, although ready and willing to work, is unemployed, and on which no remuneration is payable and for which the employee has registered, as required by this part. The amount of

compensable days of unemployment shall be computed in accordance with this section.

(b) *Registration period.* Except for registration periods in extended unemployment benefit periods, a ''registration period'' means a period of 14 consecutive days beginning with the first day for which an employee registers following:

(1) His or her last day of work, or

(2) The last day of the employee's last preceding registration period, and with respect to which the employee properly files a claim for benefits on such form and in such manner as the Board prescribes.

(c) *General waiting period.* Benefits are payable to any qualified employee for each day of unemployment in excess of seven during his or her first registration period in a period of continuing unemployment if such period of continuing unemployment is his or her initial period of continuing unemployment beginning in the benefit year, and then for each day of unemployment in excess of four during any subsequent registration period within the same period of continuing unemployment. A strike waiting period, described in paragraph (d) of this section, will satisfy a general waiting period with respect to a benefit year.

(d) *Strike waiting period.* If a qualified employee has a period of continuing unemployment that includes days of unemployment due to a stoppage of work because of a strike in the establishment, premises, or enterprise at which he or she was last employed, no benefits are payable for his or her first 14 days of unemployment due to such stoppage of work. For subsequent days of unemployment due to the same stoppage of work, benefits are payable for days of unemployment in excess of four in each subsequent registration period within the period of continuing unemployment. If such period of continuing unemployment ends because the employee has exhausted his or her benefits as provided for under part 336 of this chapter, but the stoppage of work continues, benefits are payable for days of unemployment in excess of seven in the employee's first registration period in a new period of continuing unemployment based upon the same stoppage of work and for days of unemployment in excess of four in subsequent registration periods in the same period of continuing unemployment.

(e) *Period of continuing unemployment.* A ''period of continuing unemployment'' means a single registration period that includes more than four days of unemployment or a series of consecutive periods each of which includes more than four days of unemployment, or a series of successive registration periods, each of which includes more than four days of unemployment, if each succeeding registration period begins within 15 days after the last day of the immediately preceding registration period. An employee's period of continuing unemployment ends on the last day of a benefit year in which he or she exhausts rights to unemployment benefits as provided for in part 336 of this chapter.

(f) *Computation of compensable days*—(1) *Example 1.* An employee has an initial period of continuing unemployment from June 14 through July 25 and is unemployed on all days in that period. The employee's first registration period covers June 14 to June 27, and his subsequent registration periods cover June 28 to July 11 and July 12 to July 25. Under paragraph (c) of this section, a one-week waiting period applies to his first registration period and the employee is therefore paid benefits for days of unemployment in excess of seven in that period. The employee is then paid benefits for days of unemployment in excess of four in each of the two ensuing registration periods. [Note: if this employee's period of continuing unemployment had been the result of a strike in the establishment, premises, or enterprise at which the employee was last employed, then under paragraph (d) of this section, no benefits would be payable for the period June 14 to June 27, and benefits would then be payable for days of unemployment in excess of four in each of the ensuing registration periods.]

(2) *Example 2.* Same facts as in example 1, but the employee is unemployed again beginning August 18. Since August 18 is more than 15 days after July 25, the end of his last registration period, the employee begins a new period

of continuing unemployment. The employee's first registration period in the new period of continuing unemployment covers August 18 to August 31. The employee is paid benefits for days of unemployment in excess of seven in that registration period because that period is the employee's first registration period in a new period of continuing unemployment commencing in the benefit year beginning July 1, and he or she did not previously have a waiting period in any registration period earlier in that benefit year. The employee's next registration period covers September 1 to September 14, and the employee returned to work on September 12. In that registration period, the employee has 11 days of unemployment and is therefore paid benefits for days of unemployment in excess of four.

(3) *Example 3.* Same facts as in examples 1 and 2, but the employee then has a new period of continuing unemployment beginning November 1 in the same benefit year. November 1 to November 14 is the employee's first registration period in that period of continuing unemployment. The employee is paid benefits for days of unemployment in excess of four in that registration period and for days of unemployment in excess of four in any subsequent registration period in the same benefit year because earlier in the benefit year the employee had a registration period, August 18 to August 31, in which he or she satisfied the waiting period.

(g) *Remuneration exceeds base year compensation.* (1) No benefits are payable to any otherwise eligible employee for any day of unemployment in a registration period where the total amount of remuneration, as defined in part 322 of this chapter, payable to the employee during a registration period exceeds the amount of the base year monthly compensation base. For this purpose an employee is considered to have received the amount he would have earned except for the fact that he declined suitable work available to him or her during the registration period.

(2) Days of unemployment which are not compensable by virtue of paragraph (g)(1) of this section shall nevertheless be counted as days of unemployment for purposes of determining whether the general waiting period, as described in paragraph (c) of this section, has been satisfied, and for purposes of determining a period of continuing unemployment.

(h) *Pay for time lost.* An employee may claim unemployment benefits in accordance with this part even though he or she is also pursuing a claim for pay for time lost or other remuneration. If such pay is awarded to the employee with respect to any day for which the Board has paid him or her unemployment benefits, the Board will recover the amount of unemployment benefits that was paid for any day or days for which he or she was awarded pay for time lost. See part 322 of this chapter. It is the employee's responsibility to tell the Board that he or she has filed or intends to file a claim for time lost.

[54 FR 24551, June 8, 1989, as amended at 65 FR 19647, Apr. 12, 2000]

§ 325.2 Procedure for registering for unemployment benefits.

(a) *Registering as unemployed.* To claim unemployment benefits for any day, an employee must register as unemployed by doing the following:

(1) Apply for unemployment benefits and employment service in accordance with § 325.3;

(2) File a claim in accordance with § 325.4; and

(3) Provide any other information that the Board needs to properly adjudicate his or her right to unemployment benefits.

(b) *No benefits payable without registration.* No unemployment benefits shall be paid to any otherwise qualified employee with respect to any day claimed as a day of unemployment, and no waiting period credit shall be allowed, until such time as the employee has complied with the requirements of paragraph (a) of this section.

(c) *When a registration period may begin.* When registering for unemployment benefits, an employee may claim benefits for any calendar day on which he or she is unemployed and believes himself or herself to be eligible for benefits. A registration period may begin as early as the first calendar day on

which an employee is unemployed following his or her last day of work even though such first calendar day would have been a rest day if the employee had not become unemployed. However, a registration period may not begin with any calendar day with respect to which an employee has received or will receive remuneration.

Example 1. An employee whose rest days are Saturday and Sunday is laid off on Friday, September 2, after working his regular shift on that day. His first 14-day registration period could start as early as Saturday, September 3. A registration period starting on September 3 would end on September 16. If he continues to be unemployed, his next registration period could begin September 17 and end September 30, and so forth.

Example 2. An employee whose rest days are Saturday and Sunday is laid off on Friday, September 2, but he decides to take two weeks' vacation pay covering days through Friday, September 16. Because he will have received remuneration for days through September 16, his claim for unemployment benefits could begin on Saturday, September 17, if he continues to be unemployed after his vacation ends.

Example 3. An employee whose rest days are Saturday and Sunday is laid off on Monday, September 5, after working his regular shift on that day. His first 14-day registration period could begin on Tuesday, September 6, the first day on which he was unemployed following his last day of work.

(Approved by the Office of Management and Budget under control number 3220–0166)

§ 325.3 Application for unemployment benefits and employment service.

(a) *Requirement.* An unemployed employee who wishes to claim unemployment benefits shall apply for such benefits by completing the form prescribed by the Board for that purpose. Such form shall also constitute an application for employment service. An application will be required at the beginning of each period of unemployment in a benefit year unless:

(1) The employee filed an application for an initial period of unemployment in a benefit year and has a subsequent period of unemployment within the same benefit year; or

(2) The employee had filed an application for benefits for a period of unemployment that began in the preceding benefit year and the period of unemployment continued into the next ensuing benefit year.

In either of these circumstances, the initial application will be treated as an application for days in the subsequent period of unemployment or as an application for days in the next ensuing benefit year, as the case may be.

(b) *Purpose of application.* An application for unemployment benefits and employment service is a document that serves three purposes. First, it identifies an employee who has become unemployed and wishes to begin receiving unemployment benefits. Second, it assists the Board in determining whether the applicant is a qualified employee and if so, whether any of the information reported on the application affects his or her eligibility for payment of benefits. Third, it assists the Board in placing the employee in any suitable employment that may be available.

(c) *Time for filing application.* An employee may deliver or mail his or her application to any Board office, but such application must be received at a Board office within 30 calendar days of the first day that the employee intends to claim as a day of unemployment. For example, if an employee becomes unemployed on October 31 and intends to claim unemployment benefits for days starting November 1, the application must reach a Board office no later than November 30. If the application is received December 1, the employee may not be paid unemployment benefits for November 1 as such day would not be considered as a ''day of unemployment''. If an employee returns to work and then becomes unemployed again within the same benefit year, he or she is not required to file a new application for benefits and employment service but need only contact the nearest Board office to obtain a claim form and file such form as described in § 325.4.

(d) *Extension of time for filing.* Notwithstanding paragraph (c) of this section, the Board will consider an application for unemployment benefits as timely filed if:

(1) The employee can show that he or she made a reasonable effort to file the form on time but was prevented from doing so by circumstances beyond his or her control; provided, however, that

lack of diligence, forgetfulness or lack of knowledge of the time limit for applying shall not be considered to be a circumstance beyond the employee's control; and

(2) The employee files an application within one year of the day or days that he or she claims as a day or days of unemployment.

§ 325.4 Claim for unemployment benefits.

(a) *Requirement.* After an unemployed employee has applied for unemployment benefits in accordance with § 325.3, he or she shall claim a day as a day of unemployment by registering with respect to such day. Registration shall be made on the claim form provided by the Board to the employee.

(b) *Claim.* A claim for unemployment benefits shall cover a period of 14 consecutive calendar days. Each such 14-day period shall be a registration period. An employee shall provide the information called for by the claim form and shall file his or her claim in accordance with paragraph (c) of this section.

(c) *Time for filing.* A claim for unemployment benefits shall be filed at any Board office no later than 15 calendar days after the last day of the claim period, as defined in paragraph (b) of this section, or 15 calendar days after the date on which the claim form was mailed to the employee, whichever is later. In determining whether the time for filing the claim may be extended, the standards set forth in § 325.3(d) shall be applied. None of the days included in a claim that is not timely filed shall be considered a day of unemployment.

(d) *Claim for new period of unemployment.* An employee who has complied with the application requirement under § 325.3 with respect to a period of unemployment in a benefit year, and who again becomes unemployed in the same benefit year, need not file a new application but may initiate a claim for benefits for days in such subsequent period by calling or visiting the nearest district office of the Board to request a claim form. Such request shall be made no later than 30 calendar days after the first day for which the employee wishes to claim benefits. Upon receipt of a request under this paragraph, the district office shall provide the employee with a claim form which shall show the beginning and ending dates of the registration period covered by the claim form, with the first day shown on the claim form being no earlier than the 30th day before the date on which the employee requested the claim form, unless the delay may be excused by applying the standards set forth in § 325.3(d).

(e) *Delayed claims.* If an employee makes an initial application and claim for benefits in accordance with this part but does not continue to file ongoing claims because he or she receives an initial determination denying his or her application or claim for benefits and if, upon review, the denial is reversed by an appeals referee or other authorized reviewing official, the employee shall have 30 days from the date of the notice of the reversal in which to file a claim or claims for benefits for the days that he or she would have claimed as days of unemployment but for the initial determination denying benefits. The appeals referee or other reviewing official, as appropriate, shall notify the employee of the 30-day time limit imposed by this paragraph. An employee whose claim for benefits has been denied may continue to claim any additional day or days for which he or she believes that he or she is eligible for benefits.

(f) *Claim required for waiting period.* The requirement to file a claim for unemployment benefits includes a requirement to file a claim for the noncompensable waiting period described in § 325.1(d), except that the Director of Unemployment and Sickness Insurance may waive such requirement in connection with unemployment resulting from a work stoppage or other labor dispute.

(g) *Withdrawal of claim.* An employee may withdraw his or her claim for unemployment benefits by submitting a written statement to that effect and by repaying any benefits paid on the claim, unless the employee's claim was intentionally false or fraudulent.

[54 FR 24551, June 8, 1989, as amended at 58 FR 45841, Aug. 31, 1993]

§ 325.5 Death of employee.

If an employee dies before filing one or more of the required forms, the form or forms may be filed by or in behalf of the person or persons to whom benefits would be payable pursuant to section 2(g) of the Act. Such form or forms shall be filed within the time prescribed in §325.3. Under these circumstances, the word ''employee'', as used in this part, shall include the individual or individuals by or in behalf of whom the form is filed.

§ 325.6 Verification procedures.

The Board's procedures for adjudicating and processing applications and claims for unemployment benefits filed pursuant to this part will include both pre-payment and post-payment procedures for verifying the validity of such applications and claims. Such procedures shall be designed with a view to obtaining substantial evidence as to the days of unemployment of the employees who register in accordance with this part. The verification procedures shall include, but are not limited to:

(a) Pre-payment contacts with railroad employers, utilizing data processing techniques to the extent feasible so as not to delay unduly the payment of valid claims; and

(b) Computer matching programs with state agencies or other entities that may have relevant data concerning non-railroad employment and benefit payments under state unemployment compensation laws.

PART 327—AVAILABLE FOR WORK

Sec.
327.1 Introduction.
327.5 Meaning of ''available for work''.
327.10 Consideration of availability.
327.15 Reasonable efforts to obtain work.

AUTHORITY: 45 U.S.C. 362(i), 362(l).

§ 327.1 Introduction.

The Railroad Unemployment Insurance Act provides for the payment of unemployment benefits to qualified railroad employees for days of unemployment. Under section 1(k) of the Act, an unemployed employee must be ''available for work'' as a condition of eligibility for unemployment benefits for any day claimed as a day of unemployment. This part defines the phrase ''available for work'' and explains how the Board will apply that phrase to claims for unemployment benefits.

[55 FR 1811, Jan. 19, 1990]

§ 327.5 Meaning of "available for work".

(a) *General definition.* A claimant for unemployment benefits is available for work if he is willing and ready to work.

(b) *Willing to work.* A claimant is willing to work if he is willing to accept and perform for hire such work as is reasonably appropriate to his circumstances in view of factors such as:

(1) The current practices recognized by management and labor with respect to such work;

(2) The degree of risk involved to the claimant's health, safety, and morals;

(3) His physical fitness and prior training;

(4) His experience and prior earnings;

(5) His length of unemployment and prospects for obtaining work; and

(6) The distance of the work from his residence and from his most recent work.

(c) *Ready to work.* A claimant is ready to work if he:

(1) Is in a position to receive notice of work which he is willing to accept and perform, and

(2) Is prepared to be present with the customary equipment at the location of such work within the time usually allotted.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953]

§ 327.10 Consideration of availability.

(a) *Initial proof.* A claimant who registers for unemployment benefits in accordance with the provisions of part 325 of this chapter shall, absent any evidence to the contrary, initially be considered available for work. Evidence that a claimant may not be available for work shall include any evidence provided by the claimant's base year employer(s) pursuant to section 5(b) of the Railroad Unemployment Insurance Act.

(b) *Information indicating unavailability.* If the office of the Board which is adjudicating a claimant's claims for

benefits receives information indicating that the claimant may not be available for work, he shall be required to submit evidence of his availability for work, and no benefits shall thereafter be paid with respect to any day in the period of the claimant's unemployment unless sufficient evidence of the claimant's availability for work on such day is presented.

(c) *Employee who has retired voluntarily.* An employee who has retired voluntarily shall be presumed not to be eligible for unemployment benefits. An employee shall be regarded as having retired voluntarily if his not being in the active service of his employer is due to an agreement between his labor organization and his employer requiring retirement upon attaining a certain age.

(d) *Equivalent of full-time work.* (1) A claimant who is continuously employed from week to week under a work schedule that provides the equivalent of full-time employment shall not be considered available for work with respect to any rest day or other non-work day within a 14-day registration period.

(2) The application of paragraph (d) may be illustrated by the following examples:

Example (1): A claimant's regular work schedule requires him or her to work five nine-hour days one week followed by three nine-hour days and one eight-hour day in the next week. The claimant has five non-work days within this two-week period. The claimant is not considered available for work on those non-work days.

Example (2): On Monday an employee who has been working a shift which has Saturdays and Sundays off changes to a shift which normally has Wednesdays and Thursdays off. As a consequence, the employee has six non-work days within a 14-day period. The employee is not considered available for work with respect to any of the six non-work days.

Example (3): An employee regularly receives remuneration for 40 hours per week by working 10 hours on each of four days per week, thus giving him or her six rest days in a 14-day period. The employee will not be considered available for work on the rest days.

(e) *Attendance in school or training course.* (1) A claimant who has voluntarily left work to enroll as a student in an educational institution shall be presumed not to be available for work. For the purpose of this provision, leaving work is considered voluntary when the claimant on his or her own initiative left work that he or she could have continued to perform but for the claimant's decision to attend school. In all other cases, this presumption shall not apply, but eligibility shall instead be determined on the basis of the facts of each case. In each such case, the claimant shall be given an opportunity to establish that he or she remains ready and willing to engage in full-time employment for hire, notwithstanding his or her school attendance. If a claimant is enrolled in a vocational training program at a trade or technical school, he or she shall be considered available for work if his or her current prospects for work are poor and the vocational training can reasonably be expected to increase his or her prospects for obtaining new employment.

(2) *Examples.* The application of paragraph (e) may be illustrated by the following examples:

Example (1): An individual is laid off by his or her railroad employer. Instead of looking for other employment, the individual decides to enter college in order to become a teacher. He or she is enrolled as a full-time day student. The individual is not available for work.

Example (2): An employee is furloughed by his or her railroad employer and will not likely be able to return to railroad work. After making a reasonable effort to obtain work and finding none, the individual enrolls in a six-month course of training, which upon completion would permit him or her to obtain an entry level job in the data processing industry. The individual is considered available for work while training for the data processing job.

(f) *Failure to work in anticipation of maximum mileage.* (1) An employee in train and engine service who voluntarily lays off work in anticipation of reaching the maximum mileage or earnings permitted under an agreement with his or her employer shall not be considered available for work.

(2) *Example.* Halfway through the month an engineer has worked in train service covering 2,000 miles. By agreement with his or her employer he or she may not operate a train in excess of 3,000 miles per month. In order to allow engineers with less seniority to

perform service, the engineer lays off work for five days. The engineer is not considered available for work on those days.

(g) *Confinement.* A claimant who is confined in a penal institution or is in the custody of a Federal, State or local governmental unit or official thereof shall not be considered available for work. An individual shall not be considered in the custody of a governmental unit or official thereof if he or she has been released on bail and is awaiting trial or he or she has been placed on probation or parole. However, an individual who has been released from custody by a governmental unit or official thereof under a program that permits leave from custody of a short duration, after which he or she must return to custody, shall not be considered available for work on those days on which he or she is on furlough from confinement.

(h) *Missed turns in pool service.* A train and engine service employee assigned to pool service shall not be considered as ready to work, within the meaning of §327.5(c) of this part, with respect to any day on which such employee would have worked if he or she had not missed his or her turn in pool service employment.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953, as amended by Board Order 55–30, 20 FR 1015, Feb. 17, 1955; 55 FR 1811, Jan. 19, 1990]

§327.15 Reasonable efforts to obtain work.

(a) *Requirement.* A claimant may be required at any time to show, as evidence of willingness to work, that he is making reasonable efforts to obtain work which he professes to be willing to accept and perform, unless he has good prospects of obtaining such work or his circumstances are such that any efforts to obtain work other than by making application for employment service pursuant to §325.3 of this chapter would be fruitless to the claimant.

(b) *Failure to comply with requirement.* When the office of the Board which is adjudicating claims for benefits has information that the claimant has failed to comply with the requirements set forth in paragraph (a) of this section, no benefits shall be paid with respect to any days in the period of the claimant's unemployment unless sufficient evidence of the claimant's availability for work on such days is presented.

(c) ''*What constitutes reasonable efforts.*'' A claimant shall be considered as making reasonable efforts to obtain work when he takes such steps toward obtaining work as are appropriate to his circumstances. In determining what steps are appropriate to a claimant's circumstances, consideration shall be given to actions such as:

(1) Registering with a union hiring or placement facility;

(2) Applying for employment with former employers;

(3) Making application with employers including individuals and companies not covered by the act, who may reasonably be expected to have openings in work suitable for him;

(4) Responding to appropriate ''want ads'' for work which appears suitable for him;

(5) Actively prosecuting his claim for reinstatement in his former work;

(6) Any other action reasonably directed toward obtaining work.

[Board Order 53–296, 18 FR 8157, Dec. 12, 1953, as amended at 55 FR 1812, Jan. 19, 1990]

PART 330—DETERMINATION OF DAILY BENEFIT RATES

Sec.

330.1 Introduction.
330.2 Computation of daily benefit rate.
330.3 Daily rate of compensation.
330.4 Last railroad employment in the base year.
330.5 Procedure for obtaining and using information about daily rate of compensation.

AUTHORITY: 45 U.S.C. 362(1).

SOURCE: 56 FR 28702, June 24, 1991, unless otherwise noted.

§330.1 Introduction.

The Railroad Unemployment Insurance Act provides for the payment of benefits, at a specified daily benefit rate, to any qualified employee for his or her days of unemployment or days of sickness, subject to a maximum amount per day. The ''daily benefit rate'' for an employee is the amount of benefits that he or she may receive for each compensable day of unemployment or sickness in any registration

period in a period of continuing unemployment or sickness.

[65 FR 19648, Apr. 12, 2000]

§ 330.2 Computation of daily benefit rate.

(a) *Basic formula.* A qualified employee's daily benefit rate for a given benefit year, as defined in part 302 of this chapter, is an amount equal to 60 percent of the employee's daily rate of compensation for his or her last railroad employment in the applicable base year, but such rate will not exceed the maximum amount set forth in paragraph (b) of this section nor will it be less than $12.70 per day.

(b) *Maximum daily benefit rate.* The maximum daily benefit rate is the product of the monthly compensation base, as computed under part 302 of this chapter, for the base year immediately preceding the beginning of the benefit year, multiplied by five percent. If the maximum daily benefit rate so computed is not a multiple of $1.00, the Board will round it down to the nearest multiple of $1.00.

(c) *When increase effective.* Whenever the annual application of the formula in paragraph (b) of this section triggers an increase in the maximum daily benefit rate, such increase will apply to days of unemployment or days of sickness in registration periods beginning after June 30 of the calendar year immediately following the base year referred to in paragraph (b) of this section.

(d) *Notice.* Whenever the annual application of the formula in paragraph (b) of this section triggers an increase in the maximum daily benefit rate, or if the annual application of the formula does not trigger an increase, the Board will publish a notice in the FEDERAL REGISTER explaining how it computed the maximum daily benefit rate for the year. The Board will also notify each employer of the maximum amount of the daily benefit rate. The Board will make the computation as soon as it has computed the amount of the monthly compensation base under part 302 of this chapter and will publish notice as soon as possible thereafter, but in no event later than June 1 of each year. Information as to the current amount of the maximum daily benefit rate will also be available in any Board district or regional office.

(e) *Sources of information.* In determining an employee's daily rate of compensation for the purpose of computing his or her daily benefit rate, the Board will rely on information furnished by the employee and his or her last employer in the base year. An employee's earnings from employment not covered by the Railroad Unemployment Insurance Act are not considered in computing his or her daily benefit rate.

[56 FR 28702, June 24, 1991, as amended at 65 FR 19648, Apr. 12, 2000]

§ 330.3 Daily rate of compensation.

(a) *Definition.* An employee's daily rate of compensation is his or her straight-time rate of pay, including any cost-of-living allowance provided in any applicable working agreement. It does not include any overtime pay, penalty payment, or other special allowance except as hereinafter provided. An employer's or employee's report of the daily rate of compensation shall, in the absence of information to the contrary, and subject to the considerations set forth in this section and §§ 330.4 and 330.5, be considered to show the daily rate of compensation of the employee by or for whom the report has been furnished. Where a rate other than a daily rate is reported, the Board will convert it to a daily rate.

(b) *Hourly, weekly or monthly rate.* An hourly rate shall be converted to a daily rate by multiplying such hourly rate by the number of hours constituting a working day for the employee's occupation or class of service. A weekly or monthly rate shall be converted to a daily rate by dividing such rate by the number of working days constituting the work week or work month, as the case may be, for the employee's occupation or class of service.

(c) *Mileage rate.* When a collective bargaining agreement provides for payment of compensation on a mileage basis, the employee's daily rate of compensation is his or her rate of pay for the number of miles constituting a basic day, including any allowance, as prescribed by the agreement, that is added to his or her basic rate of pay for

the number of miles constituting a basic day.

(d) *Piece rate or tonnage rate.* Where a piece rate or tonnage rate is reported, the daily rate of compensation shall be determined by computing the employee's average earnings per day for the days on which he or she worked substantially full time (excluding any overtime pay or penalty rates) at such piece rate or tonnage rate during the last two pay periods in which he or she engaged in such work in the base year.

(e) *Commissions or percentage of sales.* Where the compensation reported consists of or includes commissions or percentages of sales, the daily rate of such commissions or percentage of sales shall be determined by computing the employee's average net commissions or percentage earnings (excluding any amounts he or she received to compensate him or her for expenses) per day for the days in the last two pay periods in which he or she worked on a commission or percentage basis in the base year.

(f) *International service.* In the case of an employee who, on his last day of employment in the base year, worked partly outside the United States and partly in the United States for an employer not conducting the principal part of its business in the United States, the employee's daily rate of compensation shall be determined in the same manner as it would if all his service on that day had been rendered in the United States.

§ 330.4 Last railroad employment in the base year.

The phrase ''last railroad employment in the applicable base year,'' as used in § 330.2(a) of this part, means generally the employee's last ''service performed as an employee,'' within the meaning of section 1(g) of the Railroad Unemployment Insurance Act. If an employee did not actually perform any service as an employee in the applicable base year (the calendar year preceding a benefit year) but did receive qualifying compensation such as vacation pay or pay for time lost for days in such base year, the Board will consider that his or her last railroad employment in the base year was the employment on which the qualifying compensation was based. The daily rate of such compensation shall be deemed to be the employee's daily rate of compensation for purposes of this part. If an employee's last railroad employment in the base year was casual or temporary work and was performed while on furlough from other base year railroad employment, the Board will disregard the daily rate of compensation paid for the casual or temporary work if such rate of compensation produces a daily benefit rate lower than the daily benefit rate based on the daily rate of compensation for the employment from which the employee was furloughed.

§ 330.5 Procedure for obtaining and using information about daily rate of compensation.

(a) *Information furnished by employers.* Every employer, as defined in part 301 of this chapter, shall furnish information to the Board with respect to the daily rate of compensation of each employee for his or her last employment in the applicable base year. The employer shall make such report when it files its annual report of compensation in accordance with part 209 of this chapter and shall use the form prescribed by the Board for that purpose. If an employee's last daily rate of compensation in the base year is $99.99 or more, the employer may report such rate as $99.99 instead of the employee's actual last daily rate of compensation. In the absence of evidence to the contrary or a challenge by the employee, the daily rate of compensation provided by an employer under this section shall be used to compute a qualified employee's daily benefit rate. If an employer fails to report the last daily rate of compensation for a qualified employee who has applied for benefits or if an employee challenges the daily rate reported by an employer, the procedure in paragraphs (b) and (c) of this section will apply.

(b) *Information furnished by employee.* The Board will afford an employee an opportunity to establish his or her last daily rate of compensation if the base year employer did not report a rate for the employee on its annual report of

compensation or if the employee challenges the accuracy of the rate reported by the employer. Unless deemed unreasonable, a daily rate of compensation reported by an employee under this paragraph will be used provisionally to compute his or her daily benefit rate, but such rate will be verified in accordance with paragraph (c) of this section. In any case in which the employee's report is deemed unreasonable and no employer report has been provided, the employee's report shall be disregarded, and the Board will seek to verify the employee's last daily pay rate in accordance with paragraph (c) of this section. Pending receipt of such verification, the employee's daily benefit rate shall be set at $12.70. When an unverified and uncorrected pay rate has been verified or corrected, appropriate redetermination of the daily benefit rate shall be made, and such redetermined benefit rate shall be applied to all the employee's days of unemployment or sickness in the benefit year.

(c) *Employer verification.* Whenever an employee has established a daily rate of compensation under paragraph (b) of this section, the Board will request the employee's base year employer to verify such rate within 30 days. If such verification is not received within 30 days, the employee's daily rate of compensation may be based upon other evidence gathered by the Board if such evidence is reasonable in light of compensation rates reported for other employees of the base year employer in the same occupation or class of service as the employer or in light of previous compensation rates reported by the base year employer for its employees. A daily benefit rate established under this paragraph may not exceed the maximum daily benefit rate established under this part.

(d) *Protest.* An employee who is dissatisfied with the daily benefit rate computed under this part may contest such computation in accordance with part 320 of this chapter.

(Approved by the Office of Management and Budget under control numbers 3220–0007, 3220–0008 and 3220–0097)

PART 332—MILEAGE OR WORK RESTRICTIONS AND STAND-BY OR LAY-OVER RULES

Sec.
332.1 Statutory provisions.
332.2 General considerations.
332.3 Mileage and work restrictions.
332.4 Restrictions in extra service.
332.5 Equivalent of full-time work.
332.6 Standing by for and laying over between regularly assigned trips or tours of duty.
332.7 Consideration of evidence.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 59–95, 24 FR 3372, Apr. 30, 1959, unless otherwise noted.

§ 332.1 Statutory provisions.

* * * (1) a day of unemployment with respect to any employee, means a calendar day on which he is able to work and is available for work and with respect to which * * * no remuneration is payable or accrues to him * * * and (2) a ''day of sickness'', with respect to any employee, means a calendar day on which because of any physical, mental, psychological, or nervous injury, illness, sickness, or disease he is not able to work, or, with respect to a female employee, a calendar day on which, because of pregnancy, miscarriage, or the birth of a child, (i) she is unable to work or (ii) working would be injurious to her health, and with respect to which * * * no remuneration is payable or accrues to him * * * *Provided, further,* That any calendar day on which no remuneration is payable to or accrues to an employee solely because of the application to him of mileage or work restrictions agreed upon in schedule agreements between employers and employees or solely because he is standing by for or laying over between regularly assigned trips or tours of duty shall not be considered either a day of unemployment or a day of sickness. (Section 1(k), Railroad Unemployment Insurance Act)

[Board Order 68–72, 33 FR 11115, Aug. 6, 1968]

§ 332.2 General considerations.

(a) *Classes of service covered.* Conditions under which remuneration with respect to a day may not be payable to or accrue to an employee solely because of the application to him of a mileage or work restriction exist in train-and-engine service, yard service, dining-car service, sleeping-car service, and other Pullman-car service, and similar service, and express service on trains. In the determination of a claim for benefits of an employee in any

other service, the employee's lack of remuneration with respect to any claimed day shall be presumed not to be due solely to the application of a mileage or work restriction. Conditions under which remuneration with respect to a day may not be payable to or accrue to an employee solely because he is standing by for or laying over between regularly assigned trips or tours of duty exist in train-and-engine service, dining-car service, sleeping-car service, and other Pullman-car service, and similar service, and express service on trains. In the determination of a claim for benefits of an employee in any other service, the employee's lack of remuneration with respect to any claimed day shall be presumed not to be due solely to his standing by for or laying over between regularly assigned trips or tours of duty.

(b) *Sickness claims.* An employee who, in connection with a claim to a day as a day of sickness, is held to be not able to work because of any physical, mental, psychological, or nervous injury, illness, sickness, or disease shall not be considered to lack remuneration with respect to such day solely because of the application to him of mileage or work restrictions or solely because he is standing by for or laying over between regularly assigned trips or tours of duty. Nor shall a female employee be considered to lack remuneration with respect to a day solely because of the application to her of mileage or work restrictions or solely because she is standing by for or laying over between regularly assigned trips or tours of duty if the day is one on which, because of pregnancy, miscarriage, or the birth of a child, (1) she is unable to work or (2) working would be injurious to her health.

[Board Order 59–95, 24 FR 3372, Apr. 30, 1959, as amended at 26 FR 8593, Sept. 14, 1961; Board Order 68–72, 33 FR 11115, Aug. 6, 1968]

§ 332.3 Mileage and work restrictions.

Subject to the provisions of § 332.2(b), a day shall not be considered as a day of unemployment or as a day of sickness with respect to an employee if no remuneration is payable or accrues to him solely because of the application to him of a mileage or work restriction agreed upon in a written agreement between his employer and employees of his employer, or authorized pursuant to such written agreement. Provisions of agreements setting overtime or other premium rates of pay shall not be regarded as work restrictions. Mileage or work restrictions shall be considered as applicable to an employee with respect to any day on which he is out of service because of having reached or exceeded the maximum mileage, earnings, or hours of work prescribed in such an agreement, or authorized pursuant to such an agreement. Performance of other work by an employee while he is out of service because of having reached or exceeded the maximum mileage, earnings, or hours of work shall not serve to make the mileage or work restriction inapplicable to him.

§ 332.4 Restrictions in extra service.

Mileage or work restrictions shall be considered to exist in rotating extra board, pool, or chain gang service when there is in effect an arrangement between the employer and its employees for increasing or decreasing the number of employees in such service according to the amount of work available. When the arrangement is such that an employee in extra board, pool, or chain gang service gets the equivalent of full-time work, his lack of remuneration on any non-work day shall, subject to the provisions of § 332.2(b), be considered as due solely to the application to him of a mileage or work restriction.

§ 332.5 Equivalent of full-time work.

An employee who has the equivalent of full-time work with respect to service on days within a registration period is not eligible for unemployment benefits for any non-work days within such registration period. In determining whether an employee has the equivalent of full-time work, the Board will consider the provisions of labor-management agreements that prescribe the number of miles or hours of credit constituting a basic work day, week, or month in the employee's occupation or service. The Board will consider that an employee had the equivalent of full-time work if the number of miles or hours credited to the employee for

service in the registration period is at least 10 times the number of miles or hours constituting a basic day in the employee's occupation or service. For this purpose, any miles or hours of credit not earned because the employee missed his or her turn and any penalty miles assessed to the employee shall be added to the miles or hours of credit actually earned on the basis of service on days within the registration period.

[55 FR 1813, Jan. 19, 1990]

§ 332.6 Standing by for and laying over between regularly assigned trips or tours of duty.

Subject to the provisions of § 332.2(b), a day shall not be considered as a day of unemployment or as a day of sickness with respect to an employee if no remuneration is payable or accrues to him solely because he is standing by for or laying over between regularly assigned trips or tours of duty. Only employees who hold regular assignments may be regarded as standing by for or laying over between regularly assigned trips or tours of duty. In determining whether an employee has a regular assignment, consideration shall be given to whether the trips or tours of duty have definite starting times; whether there are a definite number of trips or tours of duty, either periodically or for the whole duration of the assignment; and whether there is a definite route of each trip or definite duration of each tour of duty. An employee who is separated from a regular assignment shall not be regarded as standing by for or laying over between regularly assigned trips or tours of duty. An employee shall be deemed separated from a regular assignment when he is suspended or discharged from service or displaced by a senior employee or held out of service for investigation or discipline, or when his regular assignment is abolished or discontinued.

§ 332.7 Consideration of evidence.

An employee shall be requested to furnish such information as to any mileage or work restrictions or as to lay-over or stand-by status as may be necessary for the determination of his claim. An employee's statement in connection with his claim that he was not out of service because of a lay-over or stand-by rule or because of a mileage or work restriction shall, in the absence of evidence to the contrary, be accepted as sufficient for a finding on that point. An employee's report of the number of miles or hours' credit earned in rotating extra board, pool, or chain gang service shall, in the absence of evidence to the contrary, be accepted as correct for purposes of determining whether he had the equivalent of full-time work during the period covered by his claim. When it appears clear that an employee in rotating extra board, pool, or chain gang service who fails to report the number of miles or hours' credit earned on days in the period covered by his claim form was not employed on enough days to have had the equivalent of full-time work in the period, no additional information as to mileage or work restrictions shall be deemed necessary for the determination of his claim.

PART 335—SICKNESS BENEFITS

Sec.

335.1 General.
335.2 Manner of claiming sickness benefits.
335.3 Execution of statement of sickness and supplemental doctor's statement.
335.4 Filing statement of sickness and claim for sickness benefits.
335.5 Death of employee.
335.6 Payment of sickness benefits.

AUTHORITY: 45 U.S.C. 362(i) and 362(l).

SOURCE: 54 FR 43057, Oct. 20, 1989, unless otherwise noted.

§ 335.1 General.

(a) *Statutory basis.* The Railroad Unemployment Insurance Act provides for the payment of sickness benefits to a qualified railroad employee for days of sickness within a period of continuing sickness. To establish basic eligibility for sickness benefits, a qualified employee must have at least four consecutive days of sickness with respect to each period of continuing sickness. The terms ''day of sickness'' and ''period of continuing sickness'' as used in this part, are defined in sections 1(k) and 2(a) of the Act, respectively, and paragraphs (b) and (c) of this section. As evidence of days of sickness based upon illness or injury or upon pregnancy, miscarriage or childbirth, section 1(k)

requires an employee to file a statement of sickness. Other information that is required to identify an employee's days of sickness is obtained by means of an application for sickness benefits at the beginning of each period of continuing sickness and by means of a claim for sickness benefits which is filed for each registration period within a period of continuing sickness. The term ''registration period'', generally refers to a period of 14 consecutive days and is defined in paragraph (d) of this section.

(b) *Day of sickness.* The term ''day of sickness'' means, in general, any calendar day, including days that would normally be rest days, on which an employee is not able to work because of any physical or mental illness or injury. With respect to a female employee, a ''day of sickness'' also includes any calendar day on which she is not able to work, or working would be injurious to her health, because of pregnancy, miscarriage or childbirth.

(c) *Period of continuing sickness.* (1) The term ''period of continuing sickness'' refers to a period of time when an employee is not able to work on account of illness, injury, sickness or disease, including inability caused by pregnancy, miscarriage or childbirth. An employee has a period of continuing sickness under either of these circumstances:

(i) He or she has any number of ''consecutive'' days of sickness based on one or more infirmities; or

(ii) He or she has any number of ''successive'' days of sickness based on a single infirmity and there is no interruption of more than 90 ''consecutive'' days which are not days of sickness.

(2) Days of sickness are ''consecutive'' when they occur one after another continuously and without interruption by any day that is not a day of sickness. Days of sickness are ''successive'' when one or more days of sickness follow any day of sickness with an interval of one or more days that are not days of sickness.

Example: An employee is sick for 11 ''consecutive'' days from October 1 through October 11, meaning that each day in the period October 1 through October 11 is a day of sickness and there is no day in that period that is not a day of sickness. If the employee also had days of sickness on October 16, 17, 18, 21 and 22, those five days are considered ''successive'' days of sickness.

(3) A period of continuing sickness with respect to any employee begins with the first day of a number of consecutive days of sickness or with the first day of a number of successive days of sickness attributable to a single cause with no interval of more than 90 days that are not days of sickness. In the example given in paragraph (c)(2) of this section, October 1 begins a period of continuing sickness. The days October 16, 17, 18, 21, and 22 are in the period of continuing sickness beginning October 1, and benefits are payable for them, provided that the employee's inability to work on those five days is due to one or more of the same infirmities that caused the employee to be unable to work on the days from October 1 through October 11. Otherwise, October 16 begins another period of continuing sickness.

(4) A period of continuing sickness ends when either of these circumstances occurs:

(i) 91 consecutive days have elapsed none of which is a day of sickness resulting from the infirmity that was the basis for the preceding days of sickness; or

(ii) One or more days that are not days of sickness have elapsed and a statement of sickness is filed with respect to a day of sickness based on an infirmity other than any infirmity causing inability on the preceding days of sickness. The end of a benefit year, generally the 12-month period beginning July 1 of any year and ending June 30 of the next year (see 45 U.S.C. 351(m)), does not end a period of continuing sickness. In the example in paragraph (c)(2) of this section, if the inability to work on October 16 was not due to an infirmity or infirmities that caused the inability to work on October 11, then a period of continuing sickness ends on October 11. A new application and statement of sickness would be required in order for the employee to be paid sickness benefits for days beginning October 16. See §335.2 of this part.

(5) A period of continuing sickness can be interrupted, provided that:

(i) The interruption is for not more than 90 consecutive days; and

(ii) The days of sickness after the interruption are due to one or more of the same causes as the days of sickness before the interruption. A period of continuing sickness can be interrupted any number of times so long as each interruption is not more than 90 days and the days of sickness are all due to the same cause. If a period of continuing sickness is caused by more than one infirmity, any one of the infirmities can be considered as the single continuing cause that will permit the interruption of the period of continuing sickness for not more than 90 days without ending it.

(d) *Registration period.* The term ''registration period'' means, with respect to any employee, the period which begins with the first day with respect to which a statement of sickness for a period of continuing sickness is filed in his or her behalf in accordance with this part, or the first such day after the end of a registration period which will have begun with a day with respect to which a statement of sickness for a period of continuing sickness was filed in his or her behalf, and ends with whichever is the earlier of:

(1) The thirteenth day thereafter; or

(2) The day immediately preceding the day with respect to which a statement of sickness for a new period of continuing sickness is filed in his or her behalf. However, each of the successive 14-day periods in an extended sickness benefit period shall constitute a registration period.

(e) *Liability for infirmity.* When sickness benefits are paid to an employee on the basis of an infirmity for which he or she recovers a personal injury settlement or judgment, the Board shall receive reimbursement for the sickness benefits in accordance with part 341 of this chapter.

§ 335.2 Manner of claiming sickness benefits.

(a) *Forms required for claiming benefits.* To claim sickness benefits for a period of inability to work due to an illness or injury, or in the case of a female employee, pregnancy, miscarriage, or childbirth, an employee must file the following forms:

(1) An application for sickness benefits at the beginning of each period of continuing sickness;

(2) A statement of sickness to accompany the employee's application;

(3) A claim for sickness benefits for each 14-day registration period during the employee's period of continuing sickness; and

(4) A supplemental doctor's statement, if the adjudicating office requests additional proof of the employee's inability to work.

(b) *Mailing or delivering the forms.* The forms required by paragraph (a) of this section may be mailed or delivered to any Board office. If the Board is satisfied that the employee is too sick or injured to execute the required forms, the Board may accept forms executed by someone in the employee's behalf. Instructions for completing and filing the forms are printed on the forms themselves.

(Approved by the Office of Management and Budget under control numbers 3220–0034, 3220–0039 and 3220–0045)

§ 335.3 Execution of statement of sickness and supplemental doctor's statement.

(a) *Who may execute.* A statement of sickness and any required supplemental doctor's statement shall be executed by any of the following individuals:

(1) A licensed medical doctor;

(2) A licensed dentist if the infirmity relates to the teeth or gums;

(3) A licensed podiatrist or chiropodist if the infirmity relates to the feet or toes;

(4) A licensed chiropractor;

(5) A clinical psychologist;

(6) A certified nurse mid-wife;

(7) The superintendent or other supervisory official of a hospital, clinic, or group health association, or similar organization, in which all examinations and treatment are conducted under the supervision of licensed medical doctors or under the supervision of licensed chiropractors, and in which medical records are maintained for each patient;

(8) A physician assistant-certified (PAC);

(9) An accredited Christian Science Practitioner;

(10) A substance-abuse professional as defined in 49 CFR part 40.3, if the infirmity involves alcohol or controlled substances-related disorders; or

(11) A nurse practitioner.

(b) *Use of Board form or other form.* The statement of sickness and supplemental doctor's statement referred to in paragraph (a) of this section shall be completed on the forms prescribed by the Board, except that other standardized medical forms may be substituted if they provide the same information as that called for by the Board's forms.

[54 FR 43057, Oct. 20, 1989, as amended at 60 FR 40073, Aug. 7, 1995; 62 FR 44408, Aug. 21, 1997; 65 FR 66499, Nov. 6, 2000]

§ 335.4 Filing statement of sickness and claim for sickness benefits.

(a) *General requirement.* Except as provided in paragraph (e) of this section, statements of sickness and claims for sickness benefits must be filed within the time limits specified by this section. Failure to comply with the time restrictions on filing claims will result in a denial of benefits for days for which timely statements and claims are not filed, as such days would not be considered days of sickness.

(b) *Statement of sickness.* An employee shall file a statement of sickness within ten calendar days of the first day that he or she wishes to claim as a day of sickness. For example, if an employee wishes to claim sickness benefits for days starting November 1, the statement of sickness should reach the Board no later than November 10. If the statement of sickness is received November 11, the employee cannot be paid sickness benefits for November 1. Such day would not be considered as a ''day of sickness'', unless the form may be considered as timely filed under paragraph (d)(3), (4) or (5) of this section.

(c) *Claim for sickness benefits.* An employee shall file a claim for sickness benefits within 30 days after the ending date shown on the claim form, or within 30 days after the date on which the Board mails the claim form to the employee, whichever date is later. Failure to comply with this provision shall bar the payment of sickness benefits with respect to any day included within the calendar period covered by the claim form.

Example: If a form for claiming sickness benefits is mailed to an employee on July 13, for the period from July 1 to July 14, the employee must file the claim within 30 days after July 14 [on or before August 13], to be paid benefits for the period July 1 to July 14. If the claim form was not mailed to the employee until July 16, the claim must be filed within 30 days after July 16 [on or before August 15].

(d) *When form considered timely filed.* The Board will consider a statement of sickness or a claim for sickness benefits as timely filed if:

(1) The statement or form was received in a Board office within the prescribed time; or

(2) The statement or form was mailed to a Board office in accordance with instructions printed on the form and was received at such office; or

(3) The employee made a reasonable effort to file the statement of sickness or claim form within the prescribed time but was prevented from doing so by circumstances beyond his or her control, and such statement or claim was received at a Board office within a reasonable time following the removal of the circumstances that prevented the employee from filing the form. The phrase ''circumstances beyond his or her control'' shall not include an employee's forgetfulness or lack of knowledge of the sickness benefit program or the time limit for filing for sickness benefits or any other lack of diligence by the employee. For the purposes of this provision, if a statement of sickness is not received within the prescribed time but is received within 30 days of the first day that an employee intends to claim as a day of sickness, the Board will consider that the employee made a reasonable effort to file the statement within the prescribed time, unless it is clear on the basis of affirmative evidence that the delay was not the result of circumstances beyond the employee's control; or

(4) The employee mistakenly registered for unemployment benefits when he or she should have applied for sickness benefits for the day or days claimed and the appropriate statement of sickness was then received at an office of the Board within a reasonable time after unemployment benefits were denied; or

(5) Notwithstanding the foregoing, any claim that is not filed within two years of the day or days claimed shall not be considered as timely filed, and such day or days shall not be considered as days of sickness.

(e) *Days for which no statement of sickness deemed filed.* A statement of sickness shall not be deemed to be filed with respect to any day in a benefit year in which the employee is not a qualified employee as defined in section 3 of the Railroad Unemployment Insurance Act or has exhausted his or her rights to sickness benefits under the Act. See part 336 of this chapter.

[54 FR 43057, Oct. 20, 1989, as amended at 57 FR 807, Jan. 9, 1992; 60 FR 40073, Aug. 7, 1995]

§ 335.5 Death of employee.

If an employee dies before filing one or more of the required forms, the form or forms may be filed by or in behalf of the person or persons to whom benefits would be payable pursuant to section 2(g) of the Railroad Unemployment Insurance Act. Such form or forms shall be filed within the time prescribed in § 335.4 of this part. Under these circumstances, the word ''employee'' as used in § 335.4(b) of this part and as used in § 335.4(d)(3) of this part shall include the individual or individuals by or in behalf of whom the form is filed. The order of distribution for benefits due but unpaid as of the date of an employee's death is the same as the order of distribution for annuities unpaid at death under the Railroad Retirement Act and may be found at § 234.31 of this title.

§ 335.6 Payment of sickness benefits.

(a) *General rule.* Except as provided in this section, benefits are payable to any qualified employee for each day of sickness after the fourth consecutive day of sickness in a period of continuing sickness, as defined in § 335.1(c), but excluding four days of sickness in any registration period in such period of continuing sickness.

(b) *Waiting period.* Benefits are payable to any qualified employee for each day of sickness in excess of seven during his or her first registration period in a period of continuing sickness if such period of continuing sickness is his or her initial period of continuing sickness beginning in the benefit year. For this purpose, the first registration period in a period of continuing sickness is the registration period that first begins with four consecutive days of sickness and includes more than four days of sickness. For the purpose of computing benefits under this section, a period of continuing sickness ends on the last day of a benefit year in which the employee exhausts rights to sickness benefits as provided for under part 336 of this chapter.

(c) *Computation of compensable days—* (1) *Example 1.* An employee has an initial period of continuing sickness from June 14 through July 25, and all days in that period are days of sickness. The employee's first registration period covers June 14 to June 27, and his or her subsequent registration period covers June 28 to July 11, and July 12 to July 25. In the one-week waiting period the employee is paid benefits for days of sickness in excess of seven. In each of the two ensuing registration periods the employee is paid benefits for days of sickness in excess of four.

(2) *Example 2.* Same facts as in Example 1, but the employee later has a new period of continuing sickness based upon a different illness or impairment beginning September 17. The employee's first registration period in his or her new period of continuing sickness covers September 17 to September 30. The employee is paid benefits for days of sickness in excess of seven in that 14-day period because that period is his or her first registration period in a new period of continuing sickness commencing in the benefit year beginning July 1, and he or she did not previously have a waiting period in any registration period earlier in the benefit year.

(3) *Example 3.* Same facts as in examples 1 and 2, but the employee then has a new period of continuing sickness beginning January 1 in the same benefit year. January 1 to January 14 is the employee's first registration period in that period of continuing sickness. The employee is paid benefits for days of sickness in excess of four in that registration period because earlier in the benefit year he or she had a registration period, September 17 to September 30, in which he or she satisfied the initial seven-day waiting period.

(d) *Amount payable.* The gross amount of sickness benefits for any registration period in a period of continuing sickness shall be computed by multiplying the number of compensable days of sickness in such registration period by the employee's daily benefit rate, as computed under part 330 of this chapter.

[65 FR 19649, Apr. 12, 2000]

PART 336—DURATION OF NORMAL AND EXTENDED BENEFITS

Subpart A—Normal Benefits

Sec.
336.1 Introduction.
336.2 Duration of normal unemployment benefits.
336.3 Duration of normal sickness benefits.
336.4 Base year compensation.
336.5 Notice to employee.

Subpart B—Extended Benefits

336.10 Eligibility.
336.11 Exhaustion of rights to normal unemployment benefits.
336.12 Exhaustion of rights to normal sickness benefits.
336.13 Years of service requirement.
336.14 Extended benefit period.
336.15 How to claim extended benefits.
336.16 Notice to employee.

AUTHORITY: 45 U.S.C. 362(l).

SOURCE: 59 FR 3996, Jan. 28, 1994, unless otherwise noted.

Subpart A—Normal Benefits

§ 336.1 Introduction.

(a) *General.* This subpart explains how long a qualified employee may receive normal unemployment or sickness benefits under the Railroad Unemployment Insurance Act during a benefit year. Under section 2(c) of that Act, normal unemployment benefits are payable for up to 130 days of unemployment within a benefit year, or in an amount equal to the amount of the employee's ''base year compensation'', whichever is less. A similar limitation applies to the payment of sickness benefits. An employee who exhausts his or her normal unemployment or sickness benefits may be eligible for payment of extended unemployment or extended sickness benefits under the conditions set forth in subpart B of this part.

(b) *Definitions.* The terms ''benefit year'', ''base year'', and ''compensation'' are defined in part 302 of this chapter. The term ''registration period'' is defined in parts 325 and 335 of this chapter. For the purposes of this subpart, and as explained in §336.4 of this part, an employee's ''base year compensation'' may include compensation in excess of the monthly compensation base (as defined in part 302 of this chapter) even though such excess may not be counted for the purpose of determining whether such employee is a ''qualified employee'' within the meaning of part 302.

(c) *Recovery of benefits.* When unemployment or sickness benefits are recovered by the Board for one or more days, the Board will disregard those days in determining whether the employee has exhausted normal unemployment or sickness benefits with respect to the applicable benefit year.

§ 336.2 Duration of normal unemployment benefits.

(a) *130 compensable day limitation.* A qualified employee who has satisfied the waiting period for a benefit year may receive benefits for a maximum of 130 days of unemployment within such benefit year, subject to the limitation on payment explained in paragraph (b) of this section. In any registration period beginning after the end of the waiting period and before the beginning of the next ensuing benefit year, benefits are payable for days of unemployment in excess of four, but the aggregate number of compensable days may not exceed 130 for the benefit year. An employee who is unemployed on all days during a registration period could have a maximum of 10 compensable days of unemployment in such registration period. The amount of benefits for each compensable day of unemployment is the amount of the daily benefit rate computed for such employee pursuant to part 330 of this chapter.

(b) *Base year compensation limit.* Notwithstanding the provisions of paragraph (a) of this section, the Board will not pay unemployment benefits to a qualified employee, with respect to his

or her days of unemployment within a benefit year, in an amount greater than the amount of his or her base year compensation, as computed under § 336.4 of this part.

(c) *Unemployment due to a strike.* The limitations set forth in paragraphs (a) and (b) of this section also apply to an employee whose unemployment is due to a stoppage of work because of a strike in the establishment, premises, or enterprise at which he was last employed. But no unemployment benefits are payable for the employee's first 14 days of unemployment due to such stoppage of work.

§ 336.3 Duration of normal sickness benefits.

The duration of normal sickness benefits is the same as the duration of normal unemployment benefits, as set forth in § 336.2 of this part. A qualified employee who has satisfied the benefit year waiting period and is otherwise eligible for sickness benefits may receive benefits for a maximum of 130 days of sickness within a benefit year, but the amount paid as sickness benefits may not exceed the amount of the employee's base year compensation, as computed under § 336.4 of this part.

§ 336.4 Base year compensation.

(a) *Formula.* For the purposes of this part, an employee's base year compensation includes any compensation in excess of the monthly compensation base (as defined in part 302 of this chapter) for any month in the applicable base year but shall not include any amount that exceeds the value of ''X'' in the following formula: X = $775(A/$600). In this formula, ''A'' is the dollar amount of the monthly compensation base with respect to months in such base year. For example, if an employee had railroad earnings of $1,500 per month in each of three months in base year 1990, the employee's base year compensation for purposes of part 302 of this chapter would be $2,235 (three times the monthly compensation base of $745 per month for months in 1990). But the employee's base year compensation for purposes of computing maximum normal unemployment (or sickness) benefits under this subpart would be $2,886 (three times $962), and his or her normal unemployment (or sickness) benefits would not be considered exhausted until he or she is paid unemployment (or sickness) benefits in an amount equal to $2,886. In this example, $962 is the amount computed as the value of ''X'' in the above formula when ''A'' is equal to $745.

(b) *Employer's duty to report.* The base year employer(s) of an employee shall provide information as to the amount of an employee's monthly compensation in excess of the monthly compensation base, as defined in part 302 of this chapter, unless the amount of the employee's compensation at the monthly compensation base limit, as already reported to the Board, is equal to or greater than an amount equal to 130 times the daily benefit rate applicable to the employee's days of unemployment or days of sickness.

(Approved by the Office of Management and Budget under control number 3220–0070)

§ 336.5 Notice to employee.

The Board will notify an employee when it appears that his or her right to normal unemployment or normal sickness benefits will be exhausted. Such notice will include information about the availability of extended benefits under subpart B of this part if the employee has completed 10 years of railroad service and the availability of normal benefits for the next ensuing benefit year if the employee is not eligible for extended benefits.

Subpart B—Extended Benefits

§ 336.10 Eligibility.

(a) Except as provided in paragraph (b) of this section, an employee may receive extended unemployment or extended sickness benefits under this part if he or she:

(1) Has exhausted normal unemployment or normal sickness benefits (as the case may be) under subpart A of this part;

(2) Has completed 10 years of railroad service, as set forth in § 336.13 of this part; and

(3) Continues to have days of unemployment or days of sickness, as the case may be.

(b) An employee is not eligible for extended sickness benefits if he or she has voluntarily retired or has attained age 65. In the case of claims for unemployment benefits, an employee is not eligible for extended unemployment benefits if he or she has voluntarily left work without good cause or has voluntarily retired.

§ 336.11 Exhaustion of rights to normal unemployment benefits.

For the purposes of this part, the Board considers that an employee has exhausted his or her current rights to normal benefits for days of unemployment if:

(a) The employee received unemployment benefits for 130 days of unemployment in the benefit year; or

(b) The employee received unemployment benefits in the benefit year equal to the amount of his or her base year compensation; or

(c) At the end of a normal benefit year during which the employee was qualified for benefits, he or she received less than the maximum unemployment benefits for the benefit year and he or she is not qualified for benefits in the next succeeding benefit year.

§ 336.12 Exhaustion of rights to normal sickness benefits.

For the purposes of this part, the Board considers that an employee has exhausted his or her current rights to normal benefits for days of sickness if:

(a) The employee received sickness benefits for 130 days of sickness in the benefit year; or

(b) The employee received sickness benefits in the benefit year equal to the amount of his or her base year compensation; or

(c) At the end of the normal benefit year during which the employee was qualified for benefits, he or she received less than the maximum sickness benefits for the benefit year and he or she is not qualified for benefits in the next succeeding benefit year.

§ 336.13 Years of service requirement.

(a) *Eligibility.* For the purposes of this part, an employee is not eligible for extended unemployment or sickness benefits if he or she does not have at least 10 years of railroad service. An employee who has 120 service months, as defined in part 210 of this chapter, whether or not consecutive, is considered to have 10 years of railroad service.

(b) *Initial determination.* The Board will determine whether an employee has 10 years of railroad service on the basis of reports filed by employers pursuant to part 209 of this chapter. The number of years of service shown in the Board's records will be accepted as correct for the purposes of this part, unless the employee claims credit for more service than that shown in the Board's records and such additional service is verified, subject to part 211 of this chapter.

(c) *Effective date.* An employee acquires ten years of railroad service as of the first day with respect to which creditable compensation is attributable in his 120th month of service.

[65 FR 19649, Apr. 12, 2000]

§ 336.14 Extended benefit period.

(a) *Defined.* An extended benefit period consists of seven consecutive 14-day registration periods.

(b) *Beginning date.* In the case of unemployment benefits, an extended benefit period begins with the first day of unemployment after the day on which the employee exhausts his or her rights to normal unemployment benefits. In the case of sickness benefits, the beginning date is the first day of sickness after the employee exhausts normal sickness benefits. Such first day of unemployment or first day of sickness must be within the same benefit year with respect to which the employee exhausted normal unemployment or normal sickness benefits, as the case may be. However, no extended benefit period may begin on any day of unemployment or sickness prior to the date on which the employee acquired 10 years of railroad service.

(c) *Ending date.* An employee's extended benefit period ends on the 97th day after it began. If an employee attains age 65 during an extended sickness benefit period, such extended benefit period will terminate on the day next preceding the date on which the employee attains age 65, except that it may continue for the purpose of paying

benefits for his or her days of unemployment, if any, during such extended period. If an extended sickness benefit period terminates because the employee has attained age 65, and if at that point the employee has rights to normal sickness benefits, the employee will be paid normal sickness benefits if he or she is otherwise entitled to payment thereof.

(d) *Maximum number of compensable days.* Extended benefits may be paid for a maximum of 65 days of unemployment (or 65 days of sickness, as the case may be) within an employee's extended benefit period.

[59 FR 3996, Jan. 28, 1994, as amended at 65 FR 19649, Apr. 12, 2000]

§ 336.15 How to claim extended benefits.

An employee who has 10 or more years of railroad service who exhausts his or her rights to normal unemployment or normal sickness benefits and who wishes to claim extended unemployment or extended sickness benefits may do so by claiming benefits on the forms provided by the Board pursuant to parts 325 or 335 of this chapter. The claim forms provided for this purpose are the same as those provided for claiming normal benefits. No special application for extended benefits is required, and no waiting period applies to the payment of extended benefits.

§ 336.16 Notice to employee.

Upon determining that an employee is eligible for a period of extended unemployment or sickness benefits, the Board will notify the employee of the beginning and ending dates of such extended benefit period.

PART 337 [RESERVED]

PART 340—RECOVERY OF BENEFITS

Sec.

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AUTHORITY: 45 U.S.C. 362(l).

SOURCE: Board Order 27–22, 32 FR 3341, Feb. 28, 1967, unless otherwise noted.

§ 340.1 Statutory provisions.

(a) Section 2(d) of the Railroad Unemployment Insurance Act provides that:

If the Board finds that at any time more than the correct amount of benefits has been paid to any individual under this Act or a payment has been made to an individual not entitled thereto (including payments made prior to July 1, 1940) recovery by adjustments in subsequent payments to which such individual is entitled under this Act or any other Act administered by the Board may, except as otherwise provided in this subsection, be made under regulations prescribed by the Board. If such individual dies before recovery is completed, recovery may be made by setoff or adjustments, under regulations prescribed by the Board, in subsequent payments due, under this Act or any other Act administered by the Board to the estate, designee, next of kin, legal representative, or surviving spouse of such individual, with respect to the employment of such individual.

Adjustments under this subsection may be made either by deductions from subsequent payments or, with respect to payments which are to be made during a lifetime or lifetimes, by subtracting the total amount of benefits paid in excess of the proper amount from the actuarial value, as determined by the Board, of such payments to be made during a lifetime or lifetimes and recertifying such payments on the basis of the reduced actuarial value. In the latter case recovery shall be deemed to have been completed upon such recertification.

There shall be no recovery in any case in which more than the correct amount of benefits has been paid to an individual or payment has been made to an individual not entitled thereto (including payments made prior to July 1, 1940) who, in the judgment of

the Board, is without fault when, in the judgment of the Board, recovery would be contrary to the purpose of this Act or would be against equity or good conscience.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him in good faith to any person where the recovery of such amount is waived under the third paragraph of this subsection or has been begun but cannot be completed under the first paragraph of this subsection.

(b) Section 2(f) of the Act provides, in part, that:

If (i) benefits are paid to any employee with respect to unemployment or sickness in any registration period, and it is later determined that remuneration is payable to such employee with respect to any period which includes days in such registration period which had been determined to be days of unemployment or sickness, and (ii) the person or company from which such remuneration is payable has, before payment thereof, notice of the payment of benefits upon the basis of days of unemployment or sickness included in such period, the remuneration so payable shall not be reduced by reason of such benefits but the remuneration so payable, to the extent to which benefits were paid upon the basis of days which had been determined to be days of unemployment or sickness and which are included in the period for which such remuneration is payable, shall be held to be a special fund in trust for the Board. * * *

(c) Section 4(a–1) of the Act provides, in part, that:

There shall not be considered as a day of unemployment or as a day of sickness, with respect to any employee— * * *

(ii) Any day in any period with respect to which the Board finds that he is receiving or will have received annuity payments or pensions under the Railroad Retirement Act of 1935 or the Railroad Retirement Act of 1937, or insurance benefits under title II of the Social Security Act, or unemployment, maternity, or sickness benefits under an unemployment, maternity, or sickness compensation law other than this Act, or any other social insurance payments under any law: *Provided,* That if an employee receives or is held entitled to receive any such payments, other than unemployment, maternity, or sickness payments, with respect to any period which include days of unemployment or sickness in a registration period, after benefits under this Act for such registration period will have been paid, the amount by which such benefits under this Act will have been increased by including such days as days of unemployment or as days of sickness shall be recoverable by the Board: *Provided further,* That, if that part of any such payment or payments, other than unemployment, maternity, or sickness payments, which is apportionable to such days of unemployment or days of sickness is less in amount than the benefits under this Act which, but for this paragraph, would be payable and not recoverable with respect to such days of unemployment or days of sickness, the preceding provisions of this paragraph shall not apply but such benefits under this Act for such days of unemployment or days of sickness shall be diminished or recoverable in the amount of such part of such other payment or payments;

(d) Section 12(o) of the Act provides that:

Benefits payable to an employee with respect to days of sickness shall be payable regardless of the liability of any person to pay damages for such infirmity. The Board shall be entitled to reimbursement from any sum or damages paid or payable to such employee or other person through suit, compromise, settlement, judgment, or otherwise on account of any liability (other than a liability under a health, sickness, accident, or similar insurance policy) based upon such infirmity, to the extent that it will have paid or will pay benefits for days of sickness resulting from such infirmity. Upon notice to the person against whom such right or claim exists or is asserted, the Board shall have a lien upon such right or claim, any judgment obtained thereunder, and any sum or damages paid under such right or claim, to the extent of the amount to which the Board is entitled by way of reimbursement.

(e) Section 3, Pub. L. 89–508, 80 Stat. 308, provides that:

(a) The head of an agency or his designee, pursuant to regulations prescribed by him and in conformity with such standards as may be promulgated jointly by the Attorney General and the Comptroller General, shall attempt collection of all claims of the United States for money or property arising out of the activities of, or referred to, his agency.

(b) With respect to such claims of the United States that have not been referred to another agency, including the General Accounting Office, for further collection action and that do not exceed $20,000, exclusive of interest, the head of an agency or his designee, pursuant to regulations prescribed by him and in conformity with such standards as may be promulgated jointly by the Attorney General and the Comptroller General, may (1) compromise any such claim, or (2) cause collection action on any such claim to be terminated or suspended where it appears that no person liable on the claim has the present or prospective financial ability to pay any significant sum thereon or that the

cost of collecting the claim is likely to exceed the amount of recovery. The Comptroller General or his designee shall have the foregoing authority with respect to claims referred to the General Accounting Office by another agency for further collection action. The head of an agency or his designee shall not exercise the foregoing authority with respect to a claim as to which there is an indication of fraud, the presentation of a false claim, or misrepresentation on the part of the debtor or any other party having an interest in the claim, or a claim based in whole or in part on conduct in violation of the antitrust laws; nor shall the head of an agency, other than the Comptroller General of the United States, have authority to compromise a claim that arises from an exception made by the General Accounting Office in the account of an accountable officer.

(c) A compromise effected pursuant to authority conferred by subsection (b) of this section shall be final and conclusive on the debtor and on all officials, agencies, and courts of the United States, except if procured by fraud, misrepresentation, the presentation of a false claim, or mutual mistake of fact. No accountable officer shall be liable for any amount paid or for the value of property lost, damaged, or destroyed, where the recovery of such amount or value may not be had because of a compromise with a person primarily responsible under subsection (b).

§ 340.2 Amount recoverable.

For purposes of this part, an ''amount recoverable'' is an amount of unemployment, sickness, or maternity benefits paid under the Railroad Unemployment Insurance Act which is:

(a) Determined to have been paid erroneously;

(b) Recoverable under section 2(f) of the Act because remuneration is found to be payable with respect to a period which includes days which had been determined to be days of unemployment or sickness;

(c) Recoverable under section 4(a–1)(ii) of the Act because of the employee's having received or been held entitled to receive annuity payments under the Railroad Retirement Act, insurance benefits under title II of the Social Security Act, unemployment, sickness or maternity benefits under any law other than the Railroad Unemployment Insurance Act, or any other social insurance payments under any law; or

(d) Recoverable under section 12(o) of the Act by virtue of the Board's right to reimbursement from any sum or damages payable through suit, compromise, settlement, judgment, or otherwise on account of liability based upon an infirmity, to the extent that it will have paid or will pay benefits for days of sickness resulting from that infirmity.

§ 340.3 When amounts recoverable to be recovered.

Amounts recoverable shall be recovered in all cases except those in which recovery is waived under § 340.10 or a compromise is approved under § 340.13.

§ 340.4 Methods of recovery of amounts recoverable.

An amount recoverable may be recovered by any one or a combination of the methods described in §§ 340.5, 340.6, 340.7, and 340.8.

§ 340.5 Recovery by cash payment.

The Board shall have the right to require that amounts recoverable be immediately and fully repaid in cash and any debtor shall have the absolute right to repay such amount recoverable in this manner. However if the debtor is financially unable to pay the indebtedness in a lump sum, payment may be accepted in regular installments. The amount and frequency of such installment payments should bear a reasonable relation to the size of the debt and the debtor's ability to pay. Whenever possible installment payments should be sufficient in amounts and frequency to liquidate the debt in not more than three years.

§ 340.6 Recovery by setoff.

An amount recoverable may be recovered by setoff against any subsequent payments to which the individual from whom the amount is recoverable is entitled under the Railroad Unemployment Insurance Act, the Railroad Retirement Act, or any other Act administered by the Board, or, in the case of that individual's death, from any payments due under those Acts to his or her estate, designee, next of kin, legal representative, or surviving spouse. In any case in which full recovery is not effected by setoff, the balance due may be recovered by one or more of the other methods described in this part. If the individual dies before

recovery is completed, such recovery shall be made from his estate or heirs.

[53 FR 2489, Jan. 28, 1988]

§ 340.7 Deduction in computation of death benefit.

In computing the residual lump sum provided for in part 234, subpart D, of this chapter, the Board shall include in the benefits to be deducted from the gross residual all amounts recoverable under this part, but not recovered, including amounts where recovery was waived, that were paid to the individual or paid to others as benefits accrued to the individual but not paid at death.

[57 FR 1379, Jan. 14, 1992]

§ 340.8 Recovery by adjustment in connection with subsequent payments under the Railroad Retirement Act.

Recovery under this part may be made by permanently reducing the amount of any annuity payable to the overpaid individual (or an individual receiving an annuity based upon the same compensation record as that of the overpaid individual) under the Railroad Retirement Act. This method of recovery is called an actuarial adjustment of the annuity. The Board cannot require any individual to take an actuarial adjustment in order to recover an overpayment nor is an actuarial adjustment available as a matter of right. An actuarial adjustment does not become effective until the overpaid individual negotiates the first annuity check which reflects the annuity rate after actuarial adjustment.

Example: An individual agrees to recovery of a $5,000 overpayment made to him by actuarial adjustment to an annuity awarded him under the Railroad Retirement Act. However, he dies before negotiating the first annuity check reflecting his actuarially reduced rate. The $5,000 is not considered recovered.

[57 FR 1379, Jan. 14, 1992]

§ 340.9 Effect of adjustment in connection with subsequent payments.

Adjustment by the method described in § 340.8 shall constitute recovery of the amount recoverable.

§ 340.10 Waiver of recovery of erroneous payments.

(a) *When waiver of recovery may be applied.* Section 2(d) of the Act provides that there shall be no recovery in any case where more than the correct amount of benefits has been paid to an individual or where payment has been made to an individual not entitled to benefits if, in the judgment of the Board:

(1) The individual is without fault; and

(2) Recovery would be contrary to the purpose of the Act or would be against equity or good conscience.

(b) *Fault.* (1) Fault means a defect of judgment or conduct arising from inattention or bad faith. Judgment or conduct is defective when it deviates from a prudent standard of care taken to comply wih the entitlement provisions of the Act. Conduct includes both action and inaction. Unlike fraud, fault does not require a deliberate intent to deceive.

(2) Whether an individual is at fault in causing erroneous payments generally depends on all circumstances surrounding the erroneous payments. Among the factors the Board will consider are: the ability of the overpaid individual to understand the reporting requirements of the Act or to realize that he or she is being overpaid (*e.g.*, age, comprehension, memory, physical and mental condition); the particular cause of benefit non-entitlement; and the number of claims on which the individual made erroneous statements.

(3) Circumstances in which the Board will find an individual at fault include but are not limited to:

(i) Failure to furnish information which the individual knew or should have known was material;

(ii) An incorrect statement made by the individual which he or she knew or should have known was incorrect (including furnishing an opinion or conclusion when asked for facts);

(iii) Failure to return a payment which the individual knew or should have known was incorrect.

(c) *When recovery defeats the purpose of the Railroad Unemployment Insurance*

Act. (1) The purpose of the Railroad Unemployment Insurance Act is to furnish some replacement for an individual's railroad earnings lost because of days of sickness or unemployment. The purpose of the Act is defeated when an erroneous payment is recovered from income and resources which the individual requires to meet ordinary and necessary living expenses. If either income or resources are sufficient to meet expenses, the purpose of the Act is not defeated by recovery of an erroneous payment.

(2) For purposes of this section, income includes any funds which may reasonably be considered available for the individual's use, regardless of source. Income to the individual's spouse or dependents is available if the spouse or dependent lived with the individual at the time waiver is considered. Types of income include, but are not limited to:

(i) Government benefits such as Black Lung, Social Security, Workers' Compensation, and Unemployment Compensation benefits;

(ii) Wages and self-employment income;

(iii) Regular payments such as rent or pensions; and

(iv) Investment income.

(3) For purposes of this section, resources include, but are not limited to, liquid assets such as cash on hand, the value of stocks, bonds, savings accounts, mutual funds, any accrual benefit payable by the United States of America or any other source.

(4) Whether an individual has sufficient income and resources to meet ordinary and necessary living expenses depends not only on the amount of his or her income and resources, but also on whether the expenses are ''ordinary and necessary.'' While the level of expenses which is ''ordinary and necessary'' may vary between individuals, it must be held at a level reasonable for an individual who is temporarily unemployed or incapacitated due to sickness. The Board will consider the discretionary nature of an expense in determining whether it is reasonable. Ordinary and necessary living expenses include:

(i) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (*e.g.*, life, accident, and health insurance), taxes, installment payments, etc.;

(ii) Medical, hospitalization, and other similar expenses;

(iii) Expenses for the support of others for whom the individual is legally responsible; and

(iv) Miscellaneous expenses (*e.g.*, newspapers, haircuts).

(5) Where recovery of the full amount of an erroneous payment would be made from income and resources required to meet ordinary and necessary living expenses, but recovery of a lesser amount would leave income or resources sufficient to meet expenses, recovery of the lesser amount does not defeat the purpose of the Act.

(d) *When recovery is against equity or good conscience*. Recovery is considered to be against equity or good conscience when a person, in reliance on such payments or on notice that such payment would be made, relinquished a valuable right or changed his or her position for the worse.

(e) *Recoveries not subject to waiver*. (1) Where an amount is recoverable pursuant to section 2(f) of the Act from remuneration payable to an employee by a person or company, or where a lien for reimbursement of sickness benefits has arisen pursuant to section 12(o) of the Act, and in either case recovery is sought from a person other than the employee, no right to waiver of recovery exists.

(2) Where the amount recoverable is equal to or less than 10 times the current maximum daily benefit rate under the Railroad Unemployment Insurance Act it shall not be considered contrary to the purpose of the Act or against equity or good conscience to recover such payment. Consequently, the amount recoverable is not subject to waiver under this part.

(3) Where the amount recoverable is the result of an overpayment of benefits payable under the Railroad Unemployment Insurance Act due to entitlement to annuities under the Railroad Retirement Act for the same days for which benefits were payable, and recovery of such overpayment may be made

by offset against an accrual of the annuities, it shall not be considered contrary to the purpose of the Act or against equity or good conscience to recover the erroneous payment by offset against such accrual. Consequently, the amount recoverable is not subject to waiver under this part.

(4) Where there exists accumulated Federal benefits payable by any executive agency of the United States, any amount recoverable which is equal to or less than the accumulated Federal benefits is not subject to waiver. Any amount recoverable which is greater than the identified accumulated Federal benefits may be considered for waiver in accordance with the provisions of this part and part 320 of this chapter.

[53 FR 2489, Jan. 28, 1988, as amended at 57 FR 1379, Jan. 14, 1992]

§ 340.11 Waiver of methods of recovery.

The Board may waive any right to recover all or any part of an amount recoverable by any one or more methods without waiving the right to recover by some other method or methods if, in the judgment of the Board, the individual is without fault and if, in the judgment of the Board, recovery by the methods waived would be against equity and good conscience and recovery by such other methods would not be against equity and good conscience.

§ 340.12 Waiver not a matter of right.

A waiver under § 340.10 or § 340.11 is not a matter of right, but is at all times within the judgment of the Board.

§ 340.13 Compromise of amounts recoverable.

The Board or its designee may compromise an amount recoverable, provided such amount does not exceed $100,000, excluding interest, or such higher amount as the Attorney General may from time to time prescribe. Compromise of an amount recoverable may not be considered in any case in which there is an indication of fraud, the presentation of a false claim or misrepresentation on the part of the debtor or his representative. Compromise is at all times within the discretionary authority of the Board or its designee.

[Board Order 27–22, 32 FR 3341, Feb. 28, 1967, as amended at 62 FR 41271, Aug. 1, 1997]

§ 340.14 Factors due to be considered in a compromise.

The following indicate the character of reasons which will be considered in approving a compromise:

(a) The debtor's ability to repay the full amount within a reasonable time;

(b) The debtor's refusal to pay the claim in full and the Board's inability to effect collection in full within a reasonable time by other collection methods;

(c) Doubt concerning the Board's ability to prove its case in court for the full amount because of a bona fide dispute as to the facts or because of the legal issues involved;

(d) The cost of collecting the amount recoverable does not justify the enforced collection of the full amount.

§ 340.15 Suspension or termination of collection action.

Collection action on a Board claim may be suspended or terminated under the following conditions:

(a) Collection action on a Board claim may be suspended temporarily when the debtor cannot be located and there is reason to believe future collection action may be productive or collection may be effected by offset in the near future.

(b) Collection action may be terminated when:

(1) The debtor is unable to make any substantial payment;

(2) The debtor cannot be located and offset is too remote to justify retention of the claim;

(3) The cost of collection action will exceed the amount recoverable;

(4) The claim is legally without merit or cannot be substantiated by the evidence.

§ 340.16 Debt collection.

(a) The Associate Executive Director for Unemployment and Sickness Insurance shall take steps to collect all delinquent debts due the Board under the benefit provisions of the Act, except those that have been classed as

uncollectible. Such steps shall commence not later than July 1, 1985 and shall include notice to each debtor of the time limit for paying the debt and the consequences of failure to pay on time.

(b) It shall be the duty of every employer or other person paying remuneration for time lost or any sum or damages for personal injury to remit the amount of reimbursement due the Board, if any, within 30 days of the date of the payment of remuneration or damages to an employee. Failure to remit the amount due within 30 days shall subject the employer or other person to interest and penalties, in addition to the principal amount due the Board.

[50 FR 36872, Sept. 10, 1985]

PART 341—STATUTORY LIEN WHERE SICKNESS BENEFITS PAID

Sec.

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AUTHORITY: Sec. 323, Pub. L. 79–572, 60 Stat. 740, 741; 45 U.S.C. 362(o).

SOURCE: 49 FR 570, Jan. 5, 1984, unless otherwise noted.

§ 341.1 Lien.

After notice in accordance with this part, the Board shall have a lien upon any sum or damages paid or payable to an employee based upon an infirmity for which the employee received sickness benefits.

§ 341.2 Sum or damages paid or payable.

(a) The term ''sum or damages paid or payable'' means the amount of money that an employee recovers because of any claim of liability based upon his or her injury or illness.

(b) The term ''sum or damages paid or payable'' does not include:

(1) An amount specified in a settlement or award as payment for any loss of property, or the amount of a settlement or award specifically apportioned as pay for lost time.

(2) An amount paid as a result of a lawsuit based on wrongful death.

(3) Workers' compensation payments.

(4) ''No-Fault'' personal-injury protection benefits or any other benefits paid under a health, sickness, accident or similar insurance policy carried by an employee.

(5) Payments made to an employee under the terms of his or her insurance policy providing for payment of all amounts that the employee is legally entitled to recover for bodily injury from the owner or operator of an uninsured motor vehicle.

§ 341.3 Notice of lien.

(a) *Notice to alleged tortfeasor.* The Board shall mail a ''Notice of Lien'' to each person or company identified as liable or potentially liable for causing the employee's infirmity. The ''Notice of Lien'' will notify the person or company of the Board's right to reimbursement. The notice shall include:

(1) The employee's name, address and social security number;

(2) The date and place of the accident; and

(3) The employee's occupation, if injured on duty.

(b) *Notice to employee.* A notice regarding repayment of sickness benefits shall be sent to an employee who names a party other than a railroad as the alleged tortfeasor.

(c) *Notice of amount of lien.* The amount of the Board's lien shall be reported, upon request, to a railroad or other person or company that may be liable for paying damages, or to the employee, or to an attorney representing any of those parties. The amount of the lien shall be reported whether or not the terms of a settlement have been agreed upon. When requested, a list showing the sickness benefits paid for each claim period may be furnished.

§ 341.4 Information required to be furnished by the employee.

(a) When applying for sickness benefits, an employee shall report the name

and address of the person or company, if any, who is alleged to have caused his or her infirmity. The employee shall also provide whatever other details are reasonably needed so that the Board may establish its lien.

(b) The employee shall, upon request, tell the Board whether and from whom he or she has collected any damages for the infirmity.

(Approved by the Office of Management and Budget under control number 3220–0036)

[49 FR 570, Jan. 5, 1984, as amended at 52 FR 11018, Apr. 6, 1987]

§ 341.5 Amount of reimbursement.

(a) The Board shall receive as reimbursement the lesser of:

(1) The amount of sickness benefits paid to the employee for the infirmity for which he or she recovers any sum or damages; or

(2) The net amount of the sum or damages paid to the employee for the infirmity, after substracting the amount of the expenses listed in paragraph (b) of this section.

(b) The expenses that may be subtracted from the amount of damages recovered are:

(1) The medical and hospital expenses that the employee incurred because of his or her injury. These expenses are deductible even if they are paid under an insurance policy covering the employee or are covered by his or her membership in a medical or hospital plan or association. But such expenses are not deductible if they are not covered by insurance or by membership in a medical or hospital plan or association and are consequently paid by a railroad or other person directly to the doctor, clinic or hospital that provided the medical care or services.

(2) The cost of litigation. This includes both the amount of the fee to which the attorney and the employee have agreed and the other expenses that the employee incurred in the conduct of the litigation itself.

§ 341.6 Report of settlement or judgment.

(a) When a person or company makes a settlement or must satisfy a final judgment based on an injury for which the employee received sickness benefits, the person or company shall notify the Board of the settlement or final judgment. That notice shall be in writing and submitted within five days of the settlement or final judgment. A railroad employer may fulfill the written notice requirement by sending an electronic message in the manner prescribed by the agency. That notification shall contain:

(1) The amount of the settlement or final judgment;

(2) The date of the settlement or final judgment; and

(3) The amount withheld from the settlement or final judgment to satisfy the Board's lien.

(b) Payment of the amount due the Board shall be delivered to the Board within 30 days after the date of the settlement agreement or the entry of final judgment.

(c) If the damages payable are to be paid directly to the court to satisfy a final judgment, thus making it impossible for the person or company to remit the amount of reimbursement due the Board, the person or company shall immediately notify the Board of the situation.

[49 FR 570, Jan. 5, 1984, as amended at 71 FR 53005, Sept. 8, 2006]

§ 341.7 Liability on Board's claim.

(a) A person or company paying any sum or damages to an employee who has received sickness benefits from the Board shall, upon receipt of notice as provided in § 341.3(a), be liable to the Board for the amount of reimbursement computed under § 341.5. This liability may be relieved by either:

(1) Withholding the amount reimbursable to the Board from the sum or damages payable to the employee, and subsequently paying that amount to the Board; or

(2) Including the U.S. Railroad Retirement Board as a payee on the check or draft along with the employee and any others who have an interest in the damages.

(b) If the person or company paying the damages does not protect the Board's lien or attempts to protect the Board's lien in some manner other than those described in paragraph (a) of this section, that person or company shall remain liable to the Board until the Board is reimbursed in full.

§ 341.8 Termination of sickness benefits due to a settlement.

(a) Sickness benefits payable to an eligible employee shall be paid without regard to whether any person or company may be liable for causing the employee's infirmity. However, the Board will terminate the payment of sickness benefits upon receipt of an oral or written report that a settlement or final judgment for the infirmity has been made. A railroad employer may file the required report by sending an electronic message in the manner prescribed by the agency.

(b) A report of settlement shall be made to the Sickness and Unemployment Benefits Section and shall include the information required in § 341.6. Where the report is an oral report, and the informant is neither the employee nor his or her representative, the informant shall be told that written confirmation containing the information called for by § 341.6 must be submitted to the Board within 5 days from the date of the oral report. A railroad employer may fulfill the written report requirement by sending an electronic message in the manner prescribed by the agency.

(c) If, in the case of an oral report, the written confirmation as described in paragraph (b) of this section is not received within five days, the Sickness and Unemployment Benefits Section shall take steps within five additional working days to verify whether there has been a settlement or final judgment. If there has been no settlement or final judgment, the payment of sickness benefits shall be reinstated.

(d) Within five days of the notification of a settlement or final judgment, the Board shall inform the employee of the report of the settlement or final judgment. The notice to the employee shall state how the employee may inform the Board that there has not been a settlement or final judgment. If the employee states that there has not been a settlement or final judgment, the adjudicating office shall, within 10 days after the receipt of such a statement, make a determination as to the employee's rights to future sickness benefits and shall notify him or her accordingly.

(e) An employee shall have the right to appeal from the determination of the amount of sickness benefits recoverable from the settlement or judgment.

An employee shall also have the right to appeal the termination of his or her sickness benefits after the report of a settlement or final judgment made in accordance with the procedures provided in paragraphs (b), (c) and (d) of this section. Such appeals shall be filed and processed in accordance with part 320 of these regulations.

[49 FR 570, Jan. 5, 1984, as amended at 71 FR 53005, Sept. 8, 2006]

§ 341.9 Board as a party; attorney's fee.

(a) The Board shall not participate in the prosecution of a personal-injury claim of an employee eligible for sickness benefits and shall neither encourage nor discourage such employee with respect to the pursuit of a claim for damages.

(b) The Board shall not be a party in any action for damages brought by an employee claiming sickness benefits under the Railroad Unemployment Insurance Act. The Board's right of reimbursement under section 12(o) of the Railroad Unemployment Insurance Act shall not be construed as giving the Board a right of subrogation or other cause of action for damages against an alleged tortfeasor. The Board shall intervene in such an action only when it is apparent that intervention may be required to protect its right of reimbursement.

(c) The Board shall not be liable for the payment of any attorney's fee or other expenses incurred in connection with such a claim for damages.

PART 344 [RESERVED]

PART 345—EMPLOYERS' CONTRIBUTIONS AND CONTRIBUTION REPORTS

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AUTHORITY: 45 U.S.C. 362(l).

SOURCE: 61 FR 20072, May 3, 1996, unless otherwise noted.

Subpart A—General Provisions and Definitions

§ 345.101 Requirement for contribution.

Every employer, as defined in part 301 of this chapter, shall pay to the Railroad Retirement Board a contribution with respect to the compensation paid to an employee in any calendar month for service by such employee (except for service to a local lodge or division of a railway labor organization). For the purposes of this part, the term ''compensation'' is defined in part 302 of this chapter. The compensation subject to contribution is the gross amount of compensation paid to an employee for service in any month, not to exceed the amount of the monthly compensation base (MCB), as defined in part 302 of this chapter. The amount of contribution payable by each employer is to be computed and paid pursuant to the provisions of this part.

§ 345.102 Multiple employer limitation.

(a) The contributions required by this part shall not apply to any amount of the aggregate compensation paid to such employee by all such employers in such calendar month which is in excess of the MCB; and

(b) Each employer (other than a subordinate unit of a national-railway-labor-organization employer) shall be liable for that portion of the contribution with respect to such compensation paid by all such employers which the compensation paid by the employer to such employee bears to the total compensation paid in such month by all such employers to such employee.

(c) In the event that the compensation paid by such employers to the employee in such month is less than the MCB, each subordinate unit of a national-railway-labor-organization employer shall be liable for such portion of any additional contribution as the compensation paid by such employer to such employee in such month bears to the total compensation paid by all national-railway-labor-organization employers to such employee in such month.

§ 345.103 Rate of contribution.

(a) Each employer will have an experience-rated rate of contribution computed by the Board under the provisions of section 8(a)(1)(C) of the Railroad Unemployment Insurance Act. See subpart D of this part.

(b) Notwithstanding paragraph (a) of this section the rate of contribution applicable to an employer that first becomes subject to this part after December 31, 1989, will be computed by the Board in accordance with section 8(a)(1)(D) of the Railroad Unemployment Insurance Act. See subpart D of this part.

§ 345.104 Employees and employee representatives not liable.

The amount of contributions for which an employer is liable under this part shall not be deducted from an employee's compensation, and the Board will not recognize any agreement under which an employee assumes liability for such contributions. Employee representatives under part 205 of this chapter are not employees for purposes of the Railroad Unemployment Insurance Act and are not liable for payment of contributions under this part.

§ 345.105 Definitions.

(a) *Chief Financial Officer.* References in this part to the Board's Chief Financial Officer mean the Chief Financial Officer, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois 60611. The Chief Financial Officer shall be responsible for assessing, collecting, and depositing contributions due from employers under this part.

(b) *Monthly compensation base.* For the purposes of this part, the monthly compensation base (MCB) is the maximum monthly amount of compensation per employee that is subject to contribution pursuant to this part. On or before December 1 of each year, the Board will compute the amount of the MCB in accordance with section 1(i) of the Railroad Unemployment Insurance Act and part 302 of this chapter, and will publish notice of the amount so computed in the FEDERAL REGISTER within 10 days after such computation has been made. Information as to the amount of the MCB should be requested from the Board's Chief Financial Officer.

(c) *Month defined.* (1) For the purposes of this part, if the date prescribed for filing a report or paying a contribution is the last day of a calendar month, each succeeding calendar month or fraction thereof during which the failure to file or pay the contribution continues shall constitute a month.

(2) If the date prescribed for filing the report or paying the contribution is a date other than the last day of a calendar month, the period that terminates with the date numerically corresponding thereto in the succeeding calendar month and each such successive period shall constitute a month. If, in the month of February, there is no date corresponding to the date prescribed for filing the report or paying, the period from such date in January through the last day of February shall constitute a month. Thus, if a report is due on January 30, the first month shall end on February 28 (or 29 if a leap year), and the succeeding months shall end on March 30, April 30, etc.

(3) If a report is not timely filed or a contribution is not timely paid, the fact that the date prescribed for filing the report or paying the contribution, or the corresponding date in any succeeding calendar month, falls on a Saturday, Sunday, or a legal holiday is immaterial in determining the number of months.

(d) *Reference to forms.* Any reference in this part to any prescribed reporting or other form of the Board includes a reference to any other form of the Board prescribed in substitution for such prescribed form.

(e) *Showing reasonable cause.* For purposes of this part if an employer exercised ordinary business care and prudence and was nevertheless unable to file the return within the prescribed time, then the delay is due to reasonable cause. A failure to pay any amount due under this part within the prescribed time will be considered to be due to reasonable cause to the extent that the employer has made a satisfactory showing that he exercised ordinary business care and prudence in providing for payment but nevertheless was unable to pay on time.

Subpart B—Reporting and Collecting Contributions

§ 345.110 Reports of compensation of employees.

The provisions of part 209 of this chapter shall be applicable to the reporting of compensation under the Railroad Unemployment Insurance Act to the same extent and in the same manner as they are applicable to the reporting of compensation under the Railroad Retirement Act.

§ 345.111 Contribution reports.

(a) *General.* (1) Except as provided in paragraph (a)(2) of this section, every employer shall, for each calendar quarter of each year, prepare a contribution report, in duplicate, on Form DC–1. If the Form DC–1 is filed electronically, no duplicate submission is required.

(2) Contribution reports of employers who are required by State law to pay compensation on a weekly basis shall include with respect to such compensation all payroll weeks in which all or the major part of the compensation falls within the period for which the reports are required.

(b) *Compensation to be reported on Form DC–1.* Employers shall enter on the employer's quarterly contribution report, prior to any additions or subtractions, the amount of creditable compensation appearing on payrolls or other disbursement documents for the corresponding quarter as the amount of creditable compensation from which the contribution payable for that quarter is to be computed.

(Approved by the Office of Management and Budget under control number 3220–0012)

[67 FR 13567, Mar. 25, 2002]

§ 345.112 Final contribution reports.

Upon termination of employer status, as determined under part 301 of this chapter, the last contribution report of the employer shall be so indicated by checking the box on the Form DC–1 entitled ''Final Report''. Such contribution report shall be filed with the Board on or before the sixtieth day after the final date for which there is payable compensation with respect to which contribution is required. The period covered by each such contribution report shall be plainly written thereon, indicating the final date for which compensation is payable. There shall be executed as part of each such final contribution report a statement giving the address at which compensation records will be kept and the name of the person keeping the records.

(Approved by the Office of Management and Budget under control number 3220–0012)

§ 345.113 Execution of contribution reports.

(a) Each contribution report on Form DC–1 shall be signed by hand by:

(1) The individual, if the employer is an individual;

(2) The president, vice president, or other duly authorized officer, if the employer is a corporation; or

(3) A responsible and duly authorized member or officer having knowledge of its affairs if the employer is a partnership or other unincorporated organization.

(b) The Form DC–1 may be filed electronically through the Board's authorized agent. If filed electronically, no further authentication is required.

[67 FR 13567, Mar. 25, 2002]

§ 345.114 Prescribed forms for contribution reports.

Each employer's contribution report, together with any prescribed copies and supporting data, shall be filled out in accordance with the instructions and regulations applicable thereto. The prescribed forms may be obtained from or accessed by contacting the Board. An employer will not be excused from making a contribution report for the reason that no form has been furnished to such employer. Application should be made to the Board for the prescribed forms in ample time to have the contribution report prepared, verified, and filed with the Board on or before the due date. Contribution reports that have not been so prepared will not be accepted and shall not be considered filed for purposes of § 345.115 of this part. In case the prescribed form has not been obtained, a statement made by the employer disclosing the period covered and the amount of compensation with respect to which the contribution is required may be accepted

as a tentative contribution report if accompanied by the amount of contribution due. If filed within the prescribed time, the statements so made will relieve the employer from liability for any penalty imposed under this part for the delinquent filing of the contribution report provided that the failure to file a contribution report on the prescribed form was due to reasonable cause and not due to willful neglect, *and provided further*, that within 30 days after receipt of the tentative report, such tentative report is supplemented by a contribution report made on the proper form.

(Approved by the Office of Management and Budget under control number 3220–0012)

[67 FR 13568, Mar. 25, 2002]

§ 345.115 Place and time for filing contribution reports.

Each employer shall file its contribution report with the Chief Financial Officer, Railroad Retirement Board, 844 North Rush Street, Chicago, Illinois, 60611–2092, or the Chief Financial Officer's designee. The employer's contribution report for each quarterly period shall be filed on or before the last day of the calendar month following the period for which it is made. If such last day falls on Saturday, Sunday, or a national legal holiday, the report may be filed on the next following business day. If mailed, reports must be postmarked on or before the date on which the report is required to be filed.

[67 FR 13568, Mar. 25, 2002]

§ 345.116 Payment of contributions.

(a) The contribution required to be reported on an employer's contribution report is due and payable to the Board without assessment or notice, at the time fixed for filing the contribution report as provided for in § 345.115 of this part.

(b) An employer shall deposit the contributions required under this part in accord with instructions issued by the Railroad Retirement Board. At the direction of the Board, the Secretary of the Treasury shall credit such contributions to the Railroad Unemployment Insurance Account in accord with section 10 of the Railroad Unemployment Insurance Act and to the Railroad Unemployment Insurance Administration Fund in accord with section 11 of the Railroad Unemployment Insurance Act.

§ 345.117 When fractional part of cent may be disregarded.

In the payment of employers' contributions to the Board a fractional part of a cent shall be disregarded unless it amounts to one-half cent or more, in which case it shall be increased to one cent.

§ 345.118 Adjustments.

(a) *In general.* If more or less than the correct amount of an employer's contribution is paid with respect to any compensation, proper adjustments with respect to the contributions shall be made, without interest, in subsequent contribution payments by the same employer, as provided for in this section.

(b) *Compensation adjustment.* A compensation adjustment is the amount of any adjustment reported by an employer on Form BA–4. See part 209 of this chapter.

(c) *Adjustment of contributions.* (1) All adjustments of contributions based on compensation adjustments shall be accounted for by the employer on the contribution report for the same quarter in which the Form BA–4 reflecting the compensation adjustments is filed with the Board.

(2) If less than the correct amount of contributions is paid for any previous calendar quarter or calendar year because of an error that does not constitute a compensation adjustment as defined in paragraph (b) of this section, the employer shall adjust the error by—

(i) Reporting the additional contribution on the next report filed after discovery of the error; and

(ii) Paying the amount thereof to the Board at the time such report is filed.

(3) If more than the correct amount of contributions is paid for any previous calendar quarter or calendar year because of an error that does not constitute a compensation adjustment as defined in paragraph (b) of this section, the employer shall adjust the error by applying the excess payment as a credit against the contribution due on the

next report filed after discovery of the error. However, if the overpayment cannot be adjusted because the employer is no longer required to file a report or because the overpayment to be adjusted exceeds the amount of contribution due on the employer's next report, the employer may file for a refund of the amount which cannot be adjusted as provided for in this section. If the overpayment is the result of an incorrect contribution rate as determined by the Board, the employer may file for a refund of the amount of overpayment or may take an adjustment as provided for in this section.

(d) *Limitations on adjustments.* No overpayment shall be adjusted under this section after the expiration of three years from the time the contribution report was required to be filed, or two years from the time the contribution was paid, whichever of such periods expires the later, or if no contribution report was filed, two years from the time the contribution was paid. Any underpayment not adjusted within the time limits as set forth in paragraph (c) of this section shall be adjusted on the employer's next contribution report or reported immediately on a supplemental return. Interest shall accrue on such underpayment as provided for in § 345.122 of this part from the time the adjustment should have been made under paragraph (c) of this section to date of payment. However, no underpayment shall be adjusted under this section after the receipt from the Board of formal notice and demand.

§ 345.119 Refunds.

(a) *In general.* If more than the correct amount of the employer's contribution is paid with respect to any compensation and the overpayment may not be adjusted in accordance with § 345.118 of this part, the amount of the overpayment shall be refunded in accordance with this section.

(b) *When permitted.* A claim for refund may be made only when the overpayment cannot be adjusted in accordance with the procedure set forth in § 345.118.

(c) *Form of claim.* A claim for refund shall be directed to the Chief Financial Officer and shall set forth all grounds in detail and all facts alleged in support of the claim, including the amount and date of each payment to the Board of the contribution to the Board, and the period covered by the contribution report on which such contribution was reported.

(d) *Claim by fiduciary.* If an executor, administrator, guardian, trustee, or receiver files a claim for refund, evidence to establish the legal authority of the fiduciary shall be annexed to the claim filed by such fiduciary under this section.

(e) *Time limit.* No refund shall be allowed after the expiration of three years from the time the contribution report was required to be filed or two years from the time the contribution was paid, whichever of such periods expires the later, or if no contribution report was filed, two years from the time the contribution was paid.

(f) *Interest.* Interest shall be payable on any contribution refunded at the overpayment rate provided for in section 6621 of the Internal Revenue Code of 1986 from the date of the overpayment to a date preceding the date of the refund check by not more than 30 days.

(g) *Refunds reduced by underpayments.* Any overpayment claimed or a refund under this section shall be reduced by the amount of any amount of any contributions previously assessed under § 345.120 of this part, which has not already been collected.

§ 345.120 Assessment and collection of contributions or underpayments of contributions.

(a) If any employer's contribution is not paid to the Board when due or is not paid in full when due, the Board may, as the circumstances warrant, assess the contribution or the deficiency and any interest or penalty applicable under this part (whether or not the deficiency is adjustable as an underpayment under § 345.118 of this part).

(b) The amount of any such assessment will be collected in accordance with the applicable provisions of law. If any employer liable to pay any contribution neglects or refuses to pay the same within ten days after notice and demand, the Board may collect such contribution with such interest and

other additional amounts as are required by law, by levy, by administrative offset as authorized by 31 U.S.C. 3716 and in accordance with the procedures set forth in part 367 of this chapter, or by a proceeding in court, but only if the levy is made or proceeding begun:

(1) Within 10 years after assessment of the contribution; or

(2) Prior to the expiration of any period, including extension thereof, for collection agreed upon by the Chief Financial Officer and the employer.

(c) All provisions of law, including penalties, applicable with respect to any tax imposed by the provisions of the Railroad Retirement Tax Act and the regulations thereunder, insofar as not inconsistent with the provisions in this part, shall be applicable with respect to the assessment and collection of contributions under this part.

§ 345.121 Jeopardy assessment.

(a) Whenever in the opinion of the Board it becomes necessary to protect the interests of the Government by effecting an immediate reporting and collection of an employer's contribution, the Board will assess the contribution whether or not the time otherwise prescribed by law for filing the contribution report and paying such contribution has expired, together with all penalties and interest thereon. Upon assessment, such contribution, and any penalty, and interest provided for under this part shall be immediately due and payable, and the Board shall thereupon issue immediately a notice and demand for payment of the contribution, penalty, and interest.

(b) The collection of the whole or any part of the amount of the jeopardy assessment may be stayed by filing with the Board a bond in an amount equal to the amount with respect to which the stay is desired, and with such sureties as the Board may deem necessary. Such bond shall be conditioned upon the payment of the amount (together with interest and any penalties thereon) the collection of which is stayed, at the time at which, but for the jeopardy assessment, such amount would be due. In lieu of surety or sureties the employer may deposit with the Board bonds or notes of the United States, or bonds or notes fully guaranteed by the United States as to principal and interest, having a par value not less than the amount of the bond required to be furnished, together with an agreement authorizing the Board in case of default to collect or sell such bonds or notes so deposited.

§ 345.122 Interest.

(a) *Rate.* If the employer's contribution is not paid to the Board when due and is not adjusted under § 345.118 of this part, interest accrues at the rate of 1 percent per month, or fraction of a month. Interest on past due contributions from the due date thereof until the date paid will be assessed after payment of the contributions, and notice and demand made upon the employer for payment thereof, in any case in which payment of the contribution is made before assessment under § 345.120.

(b) *Waiver of interest.* The Chief Financial Officer may waive, in whole or in part, any interest imposed by paragraph (a) of this section if in his or her judgment—

(1) There was a reasonable cause and not willful neglect for the late filing, late payment or underpayment, such as: the serious illness or death of an individual with the sole authority to execute the return and payment; fire, casualty, or natural disaster at the place where the railroad unemployment insurance records are kept; or reasons outside the employer's control, such as, the failure of the employer's bank to comply with the employer's filing and payment instructions;

(2) The amount of interest attributed to the delinquency is totally disproportionate to the period of the delay and the amount of contributions paid; and

(3) The employer's past record for timely compliance with railroad unemployment insurance reporting and payment requirements warrants such action considering such factors as the number and extent of delays associated with late reports, payments, and underpayments.

§ 345.123 Penalty for delinquent or false contribution reports.

(a) *Delinquent reports.* Unless waived under paragraph (b) of this section, the failure to file a contribution report on

or before the due date shall cause a penalty to accrue of five percent of the amount of such contribution if the failure is for not more than one month, with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding 25 percent in the aggregate.

(b) *Waiver of penalty.* The Chief Financial Officer may waive all or a portion of the penalty imposed under paragraph (a) of this section consistent with the criteria applicable to waiver of interest as provided for in § 345.122(b) of this part.

(c) *Penalty on net amount.* For the purpose of paragraph (a) of this section the amount of contribution required to be shown on Form DC–1 shall be reduced by the amount of any part of the contribution that is paid on or before the date prescribed for the payment of the contribution and by the amount of any credit against the contribution that may be claimed upon the DC–1.

(d) *False reports.* If a fraudulent contribution report is made, a penalty equal to 50 percent of the amount of any underpayment shall be imposed on the employer.

§ 345.124 Right to appeal the amount of a contribution, interest, or penalty.

(a) Except as otherwise provided, an employer may seek administrative review of any determination with respect to any contribution, interest, or penalty made under this part by filing a request for reconsideration with the Chief Financial Officer within 30 days after the mailing of notice of such determination. An employer shall have a right to appeal to the Board from any reconsideration decision under this section by filing notice of appeal to the Secretary to the Board within 14 days after the mailing of the decision on reconsideration. Upon receipt of a notice of an appeal, the Board may designate one of its officers or employees to receive evidence and report to the Board under the procedures set forth in part 319 of this chapter. An appeal of the contribution rate is made under § 345.307 of this part.

(b) Any appeal filed under this part shall not relieve the employer from filing any reports or paying any contribution required under this part nor stay the collection thereof. Upon the request of an employer, the Board may relieve the employer of any obligation required under this part pending an appeal. Unless specifically provided by the Board, such relief shall not stay the accrual of interest on any disputed amount as provided for in § 345.122 of this part.

[67 FR 13568, Mar. 25, 2002]

§ 345.125 Records.

Every employer subject to the payment of contributions for any calendar quarter shall, with respect to each such quarter, keep such permanent records as are necessary to establish the total amount of compensation payable to its employees, for a period of at least five calendar years after the date the contribution report to which the compensation relates was required to be filed, or the date the contribution is paid, whichever is later. The record should be in such form as to contain the information required to be shown on the quarterly contribution report. All records required by the regulations in this part shall be kept at a safe and convenient location accessible to inspection by the Board or any of its officers or employees, or by the Inspector General of the Railroad Retirement Board. Such records shall be at all times open for inspection by such officers or employees.

(Approved by the Office of Management and Budget under control number 3220–0012)

§ 345.126 Liens.

If any employer, after demand, neglects or refuses to pay a contribution required under this part, the amount of such contribution (including any interest, penalties, additional amount, or additions to such contribution, together with any costs that may accrue in addition thereto) shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such employer.

Subpart C—Individual Employer Records

§ 345.201 Individual employer record defined.

Effective January 1, 1990, the Board will establish and maintain a record, hereinafter known as an Individual Employer Record, for each employer subject to this part. As used in this subpart, ''Individual Employer Record'' means a record of each employer's benefit ratio; reserve ratio; 1-year compensation base; 3-year compensation base; unallocated charge; reserve balance; net cumulative contribution balance; and cumulative benefit balance. See § 345.302 of this part for a definition of these terms. Whenever a new employer begins paying compensation with respect to which contributions are payable under this part, the Board will establish and maintain an individual employer record for such employer.

§ 345.202 Consolidated employer records.

(a) *Establishing a consolidated employer record.* Two or more employers that are under common ownership or control may request the Board to consolidate their individual employer records into a joint individual employer record. Such joint individual employer record shall be treated as though it were a single employer record. A request for such consolidation shall be made to the Director of Assessment and Training, and such consolidation shall be effective commencing with the calendar year following the year of the request.

(b) *Discontinuance of a consolidated employer record.* Two or more employers that have established and maintained a consolidated employer record will be permitted to discontinue such consolidated record only if the individual employers agree to an allocation of the consolidated employer record and such allocation is approved by the Director of Assessment and Training. The discontinuance of the consolidated record shall be effective commencing with the calendar year following the year of the Director of Assessment and Training's approval.

[70 FR 42489, July 25, 2005]

§ 345.203 Merger or combination of employers.

In the event of a merger or combination of two or more employers, or an employer and non-employer, the individual employer record of the employer surviving the merger (or any person that becomes an employer as the result of the merger or combination) shall consist of the combination of the individual employer records of the entities participating in the merger. Where the person surviving the merger is an existing employer under part 202 of this chapter, the individual employer record for the surviving employer will not be updated to reflect the combined record until the calendar year following the year of the Board's determination. Where the entity surviving the merger becomes an employer under part 202 of this chapter by virtue of the merger, the individual employer record shall consist of the combined record effective with its employer effective date.

[70 FR 42489, July 25, 2005]

§ 345.204 Sale or transfer of assets.

(a) In the event property of an employer is sold or transferred to another employer (or to a person that becomes an employer as the result of the sale or transfer) or is partitioned among two or more employers or persons, the individual employer record of such employer shall be prorated among the employer or employers that receive the property (including any person that becomes an employer by reason of such transaction or partition), in accordance with any agreement among the respective parties (including an agreement that there shall be no proration of the employer record). Such agreement shall be subject to the approval of the Board. Where the employer acquiring the assets is an existing employer under part 202 of this chapter, that employer's individual employer record will take into consideration the acquired assets no earlier than the calendar year following the year of the Board's determination, unless an agreement among the respective parties provides otherwise. Where the employer acquiring the assets becomes an employer under part 202 of this chapter

by virtue of such acquisition, the individual employer record for such employer shall consider the acquired assets as of such person's employer effective date, subject to any agreement between the respective parties and the provisions of paragraph (b) of this section.

(b) There shall be no transfer of the employer record where an employer abandons a line of track in accordance with the provisions of the Interstate Commerce Act and the applicable regulations thereunder, and a new entity, found by the Board to be an ''employer'' under part 301 of this chapter, is formed to operate or continue service over such line; the Board will assign to such entity a new-employer contribution rate in accordance with section 8(a)(1)(D) of the RUIA and §345.304 of this part.

[61 FR 20072, May 3, 1996, as amended at 70 FR 42489, July 25, 2005]

§345.205 Reincorporation.

The cumulative benefit balance, net cumulative contribution balance, 1-year compensation base, and 3-year compensation base of an employer that reincorporates or otherwise alters its corporate identity in a transaction not involving a merger, consolidation, or unification will attach to the reincorporated or altered identity.

§345.206 Abandonment.

If an employer abandons property or discontinues service but continues to operate as an employer, the employer's individual employer record shall continue to be calculated as provided in this subpart without retroactive adjustment.

§345.207 Defunct employer.

If the Board determines that an employer has permanently ceased to pay compensation with respect to which contributions are payable under this part, the Board will, on the date of such determination, transfer the employer's net cumulative contribution balance as a subtraction from, and the cumulative benefit balance as an addition to, the system unallocated charge balance and will cancel all other accumulations of the employer. The Board's determination that an employer is defunct will be based on evidence indicating that the employer has ceased all operations as an employer and has terminated its status as an employer. In making its determination, the Board will consider evidence as described in part 202 of this chapter with respect to termination of employer status under the Railroad Retirement Act. Mere failure of an employer to pay contributions due under this part does not indicate that such employer is defunct.

§345.208 System records.

Effective January 1, 1990, the Board will establish and maintain records necessary to determine pooled charges, pooled credits, and unallocated charges for the experience rating system and will publish a notice with respect thereto no later than October 15 of each year. See §345.302 of this part for the definition of these terms.

Subpart D—Contribution Rates

§345.301 Introduction.

(a) *General.* Effective January 1, 1993, each employer that is subject to this part will have an experience-rated rate of contribution computed as set forth in §345.303 of this part. A transitional rate of contribution applies to each such employer for 1991 and 1992, in accordance with section 8(a)(1)(B) of the RUIA. An employer that first becomes subject to section 8 of the RUIA after December 31, 1989 will have a ''new-employer'' contribution rate as computed in §345.304 of this part. An employer's experience-rated contribution rate will be not less than 0.65 percent nor more than 12.5 percent. Not later than October 15 of each year, the Board will notify each employer of its experience-rated contribution rate for the following calendar year.

(b) *Components of an experience-rated contribution rate.* An employer's experience-rated contribution rate for each calendar year beginning with 1993 will be based upon the following charges:

(1) An allocated charge based upon the amount of benefits paid to employees of such employer; this charge is explained in subpart E of this part;

(2) An unallocated charge based upon a proportionate share of the system

unallocated charge balance, the computation of which is explained in § 345.302(p) of this part;

(3) A pooled charge, also referred to as risk-sharing, to cover the cost of benefit payments that are chargeable to a base year employer but are not captured by the contribution rate assigned to such employer because it is paying contributions at the maximum rate of contribution; the formula for computing the pooled charge is set forth in § 345.302(j) of this part;

(4) A surcharge of 1.5, 2.5, or 3.5 percent, or a pooled credit, depending on the balance to the credit of the Account as of June 30 of a given year; and

(5) An addition of 0.65 percent to the rate of contribution to cover the expenses incurred by the Board in administering the RUIA.

(c) *Maximum rate of contribution.* Notwithstanding any provision of this part, an employer's contribution rate for any calendar year shall be limited to 12 percent, except when a surcharge of 3.5 percent is in effect with respect to that calendar year. If a 3.5 percent surcharge is in effect, the maximum contribution limit with respect to that calendar year is 12.5 percent. The surcharge rate for a calendar year will be 3.5 percent when the balance to the credit of the Account is less than zero. The Board will compute the surcharge rate in accordance with § 345.302(n) of this part.

§ 345.302 Definition of terms and phrases used in experience-rating.

(a) *Account.* The Railroad Unemployment Insurance Account established by section 10 of the Railroad Unemployment Insurance Act (RUIA) and maintained by the Secretary of the Treasury in the unemployment trust fund established pursuant to section 904 of the Social Security Act. Benefits paid under the RUIA for an employee's days of unemployment or days of sickness are paid from this Account.

(b) *Benefit ratio.* This ratio is computed for each employer as of any given June 30 by dividing all benefits charged to the employer under subpart E of this part during the 12 calendar quarters ending on such June 30 by the employer's three-year compensation base as of such June 30, as computed under paragraph (q) of this section. The ratio is computed to four decimal places.

(c) *Benefits.* Benefits are money payments paid or payable by the Board to a qualified employee with respect to his or her days of unemployment or days of sickness, as provided by the RUIA.

(d) *Compensation.* This term has the meaning given in part 302 of this chapter.

(e) *Contributions.* Contributions are the money payments paid or payable by an employer subject to this part with respect to the compensation paid or payable to employees of such employer.

(f) *Cumulative benefit balance.* An employer's cumulative benefit balance as of any given June 30 is determined by adding:

(1) The net amount of the benefits charged to the employer under subpart E on or after January 1, 1990, and

(2) The cumulative amount of the employer's unallocated charges on and after January 1, 1990, as computed under paragraph (r) of this section.

(g) *Fund.* The Railroad Unemployment Insurance Administration Fund established by section 11 of the RUIA and maintained by the Secretary of the Treasury in the unemployment trust fund established pursuant to section 904 of the Social Security Act. The costs incurred by the Board in administering the RUIA are paid from the Fund.

(h) *Net cumulative contribution balance.* The Board will determine an employer's net cumulative contribution balance as of any given June 30, as follows:

(1) *Step 1.* Compute the sum of all contributions paid by the employer pursuant to this part after December 31, 1989; add that portion of the tax, if any, imposed under 26 U.S.C. 3321(a) that is attributable to the surtax rate under section 7106(b) of the Railroad Unemployment Insurance and Retirement Improvement Act of 1988 (Pub. L. 100–647) and any repayment taxes paid by the employer pursuant to 26 U.S.C. 3321(a) after the outstanding balance of loans made under section 10(d) of the RUIA before October 1, 1985, plus interest, has been paid;

(2) *Step 2.* Subtract an amount equal to the amount of such contributions deposited, pursuant to section 8(i) of the RUIA, to the credit of the Fund; and

(3) *Step 3.* Add an amount equal to the aggregate amount by which such contributions were reduced in prior calendar years as a result of pooled credits, if any, under paragraph (k) of this section.

(i) *One-year compensation base.* An employer's one-year compensation base is the aggregate amount of compensation with respect to which the employer is liable for contributions under this part in the four calendar quarters ending on such June 30.

(j) *Pooled charge ratio.* The pooled charge ratio, when applicable, is a pro-rata increase in the rate of contribution assigned to each employer that is not already paying contributions at the maximum rate. A pooled charge will become applicable to each such employer during a calendar year when the Account loses income because one or more other employers are paying contributions at the maximum rate (12 or 12.5 percent) rather than at the higher experience-based rate that their benefit charges would otherwise require. The pooled charge ratio thus picks up the cost of benefits paid to employees of employers whose rate of contribution is capped at the maximum rate. The pooled charge ratio for a calendar year is the same for all employers whose rate is less than the maximum and is computed as follows:

(1) *Step 1.* For each employer paying contributions at the maximum contribution limit under § 345.301(c) of this part, compute the amount of contributions that such employer would have paid if its experience-based rate were applied to its one-year compensation base as of the preceding June 30 and by then deducting from such amount the amount derived by applying the maximum contribution rate to the same one-year compensation base. For the purposes of this computation, the experience-based rate is the rate computed for such employer under § 345.303 of this part.

(2) *Step 2.* After the amount is computed for each employer in accordance with Step 1 of this paragraph (j), add the amounts for all such employers. The aggregate amount so computed represents the amount of contributions not collected by the Account because of the maximum contribution limit.

(3) *Step 3.* For each employer whose experience-based rate of contribution, as computed at Step 3 of § 345.303(a) of this part, is less than zero, the percentage rate by which the employer's rate was raised in order to bring that rate to the minimum rate of zero is multiplied by the employer's 1-year compensation base. The total of the amounts so computed is subtracted from the aggregate amount computed in Step 2 of this paragraph (j).

(4) *Step 4.* Divide the net aggregate amount computed at Step 3 of this paragraph (j) by the system compensation base as of the preceding June 30, excluding from such base the one-year compensation base of each employer whose experience-based contribution rate, computed at Step 6 of § 345.303(a) of this part, exceeds the maximum contribution limit. The result is the pooled charge ratio for the current calendar year. This ratio is computed to four decimal places.

(k) *Pooled credit ratio.* Effective January 1, 1991, and on the first of each subsequent calendar year, the Board will reduce each employer's rate of contribution, as computed under § 345.303 of this part, by the amount of the pooled credit ratio, if any, applicable to such calendar year. This ratio is computed by reference to the accrual balance to the credit of the Account as of the preceding June 30. The Board will determine the amount of the pooled credit ratio, as follows:

(1) *Step 1.* First, the Board computes the accrual balance to the credit of the Account as of the close of business on the preceding June 30 in the same manner as under Step 1 of paragraph (n) of this section. There will be a pooled credit ratio for the calendar year if that balance is in excess of the greater of $250 million or of the amount that bears the same ratio to $250 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, as computed in accordance with paragraph (o) of this section.

(2) *Step 2.* If there is such an excess amount, divide that excess amount by the system compensation base as of the June 30 preceding the calendar year. The result is the pooled credit ratio applicable to each employer for the calendar year involved in the computation. This ratio is computed to four decimal places.

(l) *Reserve balance.* An employer's reserve balance is computed as of any given June 30 by subtracting its cumulative benefit balance as of such June 30 from its net cumulative contribution balance as of such June 30. An employer's net cumulative benefit balance is computed under paragraph (f) of this section and its net cumulative contribution balance under paragraph (h) of this section. An employer's reserve balance may be either positive or negative, depending upon whether its net cumulative contribution balance exceeds its cumulative benefit balance.

(m) *Reserve ratio.* This ratio is computed for each employer as of any given June 30 by dividing its reserve balance as of June 30 by its one-year compensation base as of such June 30. An employer's reserve balance is computed under paragraph (l) of this section and its one-year compensation base under paragraph (i) of this section. This ratio is computed to four decimal places; it may be either a positive or negative figure, depending on whether the employer's reserve balance is a positive or negative figure.

(n) *Surcharge rate.* Effective January 1, 1991, and on the first of each subsequent calendar year, the Board will add to each employer's rate of contribution, as computed under § 345.303 of this part, a surcharge rate of 1.5, 2.5, or 3.5 percent if the accrual balance to the credit of the Account, as of the preceding June 30, falls within the range of balances set forth in Steps 1 and 2 of this paragraph (n). The Board will determine which surcharge rate, if any, is in effect for a calendar year by means of the following computation:

(1) *Step 1.* First, the Board computes the accrual balance to the credit of the Account as of the close of business on the preceding June 30. Such balance will include any amounts in the Account attributable to loans made under section 10(d) of the Act before October 1, 1985, but not the obligation of the Account to repay such loans with interest. For this purpose, the Account will be deemed to include any balance to the credit of the Fund that exceeds $6 million. The surcharge rate, as specified in Step 2 of this paragraph (n), will apply if that balance is less than the greater of $100 million or of the amount that bears the same ratio to $100 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, as computed in accordance with paragraph (o) of this section.

(2) *Step 2.* If the balance to the credit of the Account is less than the greater of the amounts referred to in the last sentence of Step 1 of this paragraph (n), but is equal to or more than the greater of $50 million or of the amount that bears the same ratio to $50 million as the system compensation base as of that June 30 bears to the system compensation base as of June 30, 1991, then the surcharge rate for the calendar year shall be 1.5 percent. If the balance to the credit of the Account is less than the greater of the amounts referred to in this Step 2, but greater than or equal to zero, then the surcharge rate for the calendar year shall be 2.5 percent. If the balance to the credit of the Account is less than zero, the surcharge rate for the calendar year shall be 3.5 percent.

(o) *System compensation base.* The system compensation base as of June 30 of each year is the total of the amounts of the one-year compensation bases of all base year employers, computed in accordance with paragraph (i) of this section. Not later than October 15 of each year, the Board will compute the amount of the system compensation base and will publish notice of such amount in the FEDERAL REGISTER as soon as practicable thereafter.

(p) *System unallocated charge balance.* This balance, as computed initially for the period January 1 through June 30, 1990 and updated as of June 30 of each subsequent calendar year, represents the net amount of expenditures from, and income to, the Account that cannot be allocated as benefit charges, or adjustments, to the cumulative benefit

balances of individual base year employers. The Board computes this balance, as of June 30 of each year, as follows:

(1) *Step 1.* Compute the aggregate amount of all interest paid by the Account on loans from the Railroad Retirement Account after September 30, 1985, pursuant to section 10(d) of the RUIA, during the 12-month period ending on June 30;

(2) *Step 2.* Add the amount of unemployment benefits paid by reason of strikes or work stoppages growing out of labor disputes and the cumulative benefit balance of any defunct employer;

(3) *Step 3.* Add the aggregate amount of any other benefit payment that is not chargeable to a base year employer pursuant to subpart E of this part and any other expenditure not chargeable to the Fund;

(4) *Step 4.* Subtract the aggregate amount of income to the Account received as a proportionate part of the earnings of the unemployment trust fund, computed in accordance with section 904(e) of the Social Security Act, and all income to the Account received as fines or penalties collected under the RUIA;

(5) *Step 5.* Subtract the aggregate amount of all transfers from the Fund to the Account pursuant to section 11(d) of the RUIA;

(6) *Step 6.* Subtract the aggregate amount of any other cash receipt to the Account that cannot be treated as an adjustment to the benefit charges of a base year employer;

(7) *Step 7.* Subtract the net cumulative contribution balance of any defunct employer, calculated as of the date on which the Board determines that such employer is defunct. After the Board has computed the amount of the system unallocated charge balance as of June 30 of each year, the Board will publish notice of such amount in the FEDERAL REGISTER on or before October 15 of such year.

(q) *Three-year compensation base.* An employer's three-year compensation base as of any given June 30 is the aggregate amount of compensation with respect to which the employer is liable for contributions under this part in the 12 calendar quarters ending on such June 30.

(r) *Unallocated charge.* An employer's unallocated charge as of any given June 30 is the amount that, as of such June 30, bears the same ratio to the system unallocated charge balance as the employer's 1-year compensation base bears to the system compensation base. The system unallocated charge balance is computed under paragraph (p) of this section and the system compensation base under paragraph (o) of this section.

§ 345.303 Computation of rate.

(a) With respect to compensation in a calendar year that begins after December 31, 1992, the Board will compute, by October 15, 1992, and by October 15 of each subsequent year, a contribution rate for each employer (other than a new employer) in accordance with the following 8-step process:

(1) *Step 1.* Compute the employer's *benefit ratio* as of the preceding June 30;

(2) *Step 2.* Compute the employer's *reserve ratio* as of the preceding June 30 and subtract it from the *benefit ratio;*

(3) *Step 3.* Subtract the *pooled credit ratio* (if any) for the calendar year;

(4) *Step 4.* Multiply the Step 3 result by 100, in order to obtain a percentage rate, and then round such rate to the nearest 100th of one percent. If the rate so computed is zero or less than zero, the percentage rate will be deemed zero at this point;

(5) *Step 5.* Add 0.65 (the administrative charge) to the percentage rate computed through Step 4.

(6) *Step 6.* Add the *surcharge rate* (if any) for the calendar year;

(7) *Step 7.* Add the *pooled charge ratio* (if any) for the calendar year, as computed to four decimal places and multiplied by 100;

(8) *Step 8.* If the rate computed through Step 7 is greater than 12 percent (or 12.5 percent if a surcharge of 3.5 percent is in effect for the calendar year), reduce the percentage rate so computed to 12 percent or 12.5 percent, if appropriate.

(b) The percentage rate computed under paragraph (a) of this section is the employer's rate of contribution for the calendar year in question.

(c)(1) Any computation that is to be made under this section on the basis of a 12-quarter period ending on a given June 30 shall be made on the basis of a period beginning on January 1, 1990, or on the first day of the first calendar quarter that begins after the date on which the employer first began to pay compensation subject to this part, or on July 1 of the third calendar year preceding that June 30, whichever date is later, and ending on that June 30.

(2) The amount computed under paragraph (c)(1) of this section shall be increased to an amount that bears the same ratio to the amount so computed as 12 bears to the number of calendar quarters on which the computation is based.

§ 345.304 New-employer contribution rates.

(a) An employer whose coverage under the RUIA becomes effective after December 31, 1989, is considered a ''new employer'' for the purposes of this part and will be assigned a contribution rate as computed under this section. The Board shall determine where an employer is a new employer and, if so, the effective date of its coverage under the RUIA and its rate of contribution with respect to compensation paid to employees on and after such effective date.

(b) *Initial contribution rate.* The rate of contribution with respect to compensation paid in calendar months before the end of the first full calendar year that the employer is subject to this section shall be the average contribution rate paid by all employers during the three calendar years preceding the calendar year before the calendar year in which the compensation is paid. The Board will compute the average contribution rate by dividing the aggregate contributions paid by all employers during those three calendar years by the aggregate compensation with respect to which such contributions were paid and by then multiplying the resulting ratio, as computed to four decimal points, by 100.

(c) *Second contribution rate.* The rate of contribution with respect to compensation paid in months in the second full calendar year shall be the smaller of the maximum contribution limit under the RUIA or the percentage rate computed as follows:

$$R = \frac{2(A2) + B}{3}$$

(d) *Third contribution rate.* The rate of contribution with respect to compensation paid in months in the third full calendar year shall be the smaller of the maximum contribution limit under the RUIA or the percentage rate computed as follows:

$$R = \frac{A3 + 2C}{3}$$

(e) *Subsequent calendar years.* The rate of contribution with respect to months after the third full calendar year shall be determined under § 345.303 of this part.

(f) *Meaning of symbols.* For the purpose of the formulas in paragraphs (c) and (d) of this section, ''R'' is the applicable contribution rate being computed; ''A2'' is the contribution rate that would have been determined under paragraph (b) of this section if the employer's second calendar year had been its first full calendar year; ''A3'' is the contribution rate that would have been determined under paragraph (b) of this section, if the employer's third calendar year had been such employer's first full calendar year; ''B'' is the contribution rate for the employer as determined under § 345.303 of this part for the employer's second full calendar year; and ''C'' is the contribution rate for the employer as determined under § 345.303 of this part for the employer's third full calendar year.

(g) *Special rule for certain computations.* For purposes of computing ''B'' and ''C'' in the formulas in this section, the percentage rate computed under § 345.303 shall not be reduced under Step 8 of that section; and any computations that, under § 345.303, are to be made on the basis of a 4-quarter or 12-quarter period ending on a given June 30 shall be made on the basis of a period commencing with the first day of the first calendar quarter that begins after the date on which the employer first began paying compensation subject to this part and ending on that June 30, and the amount so computed

shall be increased to an amount that bears the same ratio to the amount so computed as four or twelve, as appropriate, bears to the number of calendar quarters in the period on which the computation was based.

§ 345.305 Notification and proclamations.

(a) *Quarterly notifications to employers.* Not later than the last day of any calendar quarter that begins after March 31, 1990, the Board will notify each employer of its cumulative benefit balance and its net cumulative contribution balance as of the end of the preceding calendar quarter, as computed in accordance with § 345.302(f) and (h) of this part as of the last day of such preceding calendar quarter rather than as of a given June 30 if such last day is not a June 30.

(b) *Annual notifications to employers.* Not later than October 15, 1990, and October 15 of each year thereafter, the Board will notify each employer of its benefit ratio, reserve ratio, one-year compensation base, three-year compensation base, unallocated charge, and reserve balance as of the preceding June 30, as computed in accordance with this part, and of the contribution rate applicable to the employer for the following calendar year as computed under the applicable section of this part.

(c) *Proclamations.* Not later than October 15, 1990, and October 15 of each year thereafter, the Board shall proclaim—

(1) The balance to the credit of the Account as of the preceding June 30 for purposes of computing the pooled credit ratio and the surcharge rate of contribution;

(2) The balance of any advances to the Account under section 10(d) of the RUIA after September 30, 1985, that has not been repaid with interest as provided in such section as of September 30 of that year;

(3) The system compensation base as of that June 30;

(4) The system unallocated charge balance as of that June 30; and

(5) The pooled credit ratio, the pooled charge ratio, and the surcharge rate of contribution, if any, applicable in the following calendar year.

(d) *Publication and notice.* As soon as practical after the Board has determined and proclaimed the amounts specified in paragraph (c) of this section, the Board will publish notice of such amounts in the FEDERAL REGISTER. The notifications to employers under paragraphs (a) and (b) of this section will be sent to the employer official designated to receive them.

§ 345.306 Availability of information.

Upon request of an employer subject to this part, the Board will make available to such employer any information that is necessary to verify the accuracy of its rate of contribution, as determined by the Board, including information necessary to verify the accuracy of the data maintained by the Board in the employer's individual employer record.

§ 345.307 Rate protest.

(a) *Request for reconsideration.* An employer may appeal a determination of a contribution rate computed under this part by filing a request for reconsideration with the Director of Assessment and Training within 90 days after the date on which the Board notified the employer of its rate of contribution for the next ensuing calendar year. Within 45 days of the receipt of a request for reconsideration, the Director shall issue a decision on the protest.

(b) *Appeal to the Board.* An employer aggrieved by the decision of the Director of Assessment and Training under paragraph (a) of this section may appeal to the Board. Such appeal shall be filed with the Secretary to the Board within 30 days after the date on which the Director notified the employer of the decision on reconsideration. The Board may decide such appeal without a hearing or, in its discretion, may refer the matter to a hearings officer pursuant to part 319 of this chapter.

(c) *Decision of the Board final.* Subject to judicial review provided for in section 5(f) of the RUIA, the decision of the Board under paragraph (b) of this section is final with respect to all issues determined therein.

(d) *Waiver of time limits.* A request for reconsideration or appeal under this section shall be forfeited if the request or appeal is not filed within the time

prescribed, unless reasonable cause, as defined in this part, for failure to file timely is shown.

(e) *Rate pending review.* Pending review of the protested rate, the employer shall continue to pay contributions at such rate. Any adjustment in the contributions paid at such rate as the result of an appeal shall be in accordance with § 345.118 of this part.

(f) The amount of a contribution, interest, or penalty may be protested in accord with § 345.124 of this part.

[67 FR 13568, Mar. 25, 2002]

Subpart E—Benefit Charging

§ 345.401 General rule.

Effective January 1, 1990, all benefits paid to an employee for his or her days of unemployment or days of sickness will be charged to the base year employer of such employee, except as hereinafter provided in this part. The Board will make the charge by adding the gross amount of the benefits payable to an employee on the basis of a claim for benefits to that employee's base year employer's cumulative benefit balance. The benefit charge does not depend on whether the employee receiving the benefit payment is a current employee of the base year employer.

§ 345.402 Strikes or work stoppages.

If benefits are payable to an employee for days of unemployment resulting from a strike or work stoppage growing out of a labor dispute, the Board will charge the benefit payment to the system unallocated charge balance, not to the cumulative benefit balance of the employee's base year employer. For the purposes of this section, the phrase ''strike or work stoppage growing out of a labor dispute'' does not include an employee's protected refusal to work under section 212(b) of the Federal Railroad Safety Act of 1970 (45 U.S.C. 441(b)).

§ 345.403 Multiple base year employers.

(a) *General rules for benefit charging.* All benefits paid to an employee who had more than one base year employer shall be charged to the cumulative benefit balances of such employers, as follows:

(1) If the employer at the time of the claim is the same as the last employer in the base year, benefits will be charged in reverse chronological order, but the amount charged to each base year employer shall not exceed the amount of compensation paid by such employer to the employee in the base year;

(2) In all other cases, benefits will be charged in the same ratio as the compensation paid to such employee by the employer bears to the total of such compensation paid to such employee by all such employers in the base year; benefit charging in accordance with this method shall apply whether the base year employment was with successive employers or with concurrent employers.

(b) *Excess benefit payments.* If, in applying the rule in paragraph (a)(1) of this section, there remain benefit payments, in whole or in part, that cannot be charged to any base year employer, the amount of benefits paid in excess of those chargeable under paragraph (a)(1) shall be charged to the system unallocated charge balance.

(c) *Board records as basis for charging multiple base year employers.* Where an employee has more than one base year employer, the Board will use records compiled on the basis of employer reports filed under § 345.110 of this part for the purpose of determining whether the employer at the time of the claim for benefits is the last employer in the base year and for other purposes related to benefit charging under this subpart. If, in a particular case, such records do not contain all the data necessary to determine the charge, the Board will request the necessary data from the base year employers who may be liable for the charge.

§ 345.404 Adjustments.

(a) *Recovery of benefits charged to base year employer.* Where the Board recovers a benefit payment that it had previously charged, in whole or in part, to one or more base year employers, the Board will subtract the amount of the recovery from the cumulative benefit balances of the employers of the employee to whom such amount was paid

as a benefit in proportion to the amount by which each such employer's cumulative benefit balance was increased as a result of the payment of the benefit.

(b) *Recovery of other benefit payments.* Where the Board recovers a benefit payment that was not charged, in whole or in part, to any base year employer, or was made before January 1, 1990, the Board will treat the amount of the recovery as a subtraction from the system unallocated charge balance.

(c) *Payment of interest or other debt collection-related charges.* The Board will not adjust a base year employer's cumulative benefit balance to reflect payment by a debtor of interest or other charges assessed by the Board under §200.7 of this chapter with respect to the collection of a debt arising from a benefit payment charged to such employer and later found to be recoverable by the Board.

(d) *Limitations.* The Board will adjust a base year employer's cumulative benefit balance only when the Board actually recovers, by cash payment or setoff, a debt that represents a benefit payment that was charged, in whole or in part, to such employer. No adjustment shall be made—

(1) If the Board waives recovery of a debt in accordance with part 340 of this chapter, or

(2) If the Board finds that a debt is uncollectible, or

(3) To the extent of the amount not recovered by the Board by reason of a compromise settlement of a debt.

§ 345.405 Notices to base year employers.

(a) *Prepayment notification.* When the Board receives an employee's claim for unemployment or sickness benefits, the Board will give the employee's base year employer notice of the claim and an opportunity to provide information to the Board with respect to the employee's eligibility for benefits for the period of time covered by the claim.

(b) *Notice of claim determination.* After the base year employer has had an opportunity to provide information in accordance with the prepayment notification process described in paragraph (a) of this section, the office of the Board that is adjudicating the employee's claim for benefits will determine whether to pay or to deny benefits on the claim. Such office will send notice to the base year employer showing what determination was made on the claim. If benefits are found to be payable, the amount of the payment will be charged to the cumulative benefit balance of the base year employer in accordance with the provisions of this subpart. If the base year employer disagrees with the payment of benefits, it may request reconsideration in accordance with part 320 of this chapter.

(c) *Quarterly notice of benefit charges.* As soon as practical following the end of each calendar quarter, the Board will send to each employer a report of its cumulative benefit balance computed as of the end of such quarter. The computation of such balance will reflect the following:

(1) The total amount of unemployment and sickness benefit payments made after December 31, 1989, that have been charged to the employer as the base year employer of the employees who received the benefits; minus

(2) The total amount realized in recovery of such benefits; plus

(3) The total amount of the unallocated charges assigned to such base year employer after December 31, 1989; minus

(4) The total amount realized in recovery of such unallocated charges.

§ 345.406 Defunct employer.

Whenever the Board determines, pursuant to §345.207 of this part, that an employer is defunct, the Board will add the amount of such employer's benefit charges, as shown in its cumulative benefit balance, to the system unallocated charge balance.

PART 346—RAILROAD HIRING

AUTHORITY: 45 U.S.C. 362(l).

§ 346.1 Central register.

(a) The Board shall maintain a central register of railroad employees with at least one year of service who have declared their current availability for rail industry employment. The register shall indicate which of those employees claims a first right of hire.

(b) The central register shall be subdivided by class and craft of prior employment and shall be updated periodically to reflect current employee availability.

(c) Upon request, listings of employees named in the central register and selected on the basis of job experience, location of residence, claimed hiring preference, last railroad employer or other available selection criteria will be furnished to railroads. Railroads may provide written notice of job vacancies to selected employees listed on the register. The railroad notice to the employees should contain job qualification requirements and application instructions. If the railroad requests, the Board shall notify the employees of the vacancy.

[53 FR 3201, Feb. 4, 1988]

PART 348—REPRESENTATIVE PAYMENT

Sec.

348.1 Introduction.
348.2 Recognition by the Board of a person to act in behalf of another.

AUTHORITY: 45 U.S.C. 355, 45 U.S.C. 231k.

SOURCE: 61 FR 42377, Aug. 15, 1996, unless otherwise noted.

§ 348.1 Introduction.

(a) *Explanation of representative payment.* This part explains the principles and procedures that the Board follows in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds which he or she receives on behalf of a claimant. A representative payee may be either a person or an organization selected by the Board to receive benefits on behalf of a claimant. A representative payee will be selected if the Board believes that the interest of a claimant will be served by representative payment rather than direct payment of benefits. Generally, the Board will appoint a representative payee if it determines that the claimant is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Statutory authority.* Section 12 of the Railroad Retirement Act, which is also applicable to the Railroad Unemployment Insurance Act, provides that every claimant shall be conclusively presumed to have been competent until the date on which the Board receives a notice in writing that a legal guardian or other person legally vested with the care of the person or estate of an incompetent or a minor has been appointed: *Provided, however,* That despite receiving such notice, the Board may, if it finds the interests of such claimant to be served thereby, recognize actions by, conduct transactions with, and make payments to such claimant.

(c) *Policy used to determine whether to make representative payment.* (1) The Board's policy is that every claimant has the right to manage his or her own benefits. However, due to mental or physical condition some claimants may be unable to do so. If the Board determines that the interests of a claimant would be better served if benefit payments were certified to another person as representative payee, the Board will appoint a representative payee in accordance with the procedures set forth in this part. The Board may appoint a representative payee even if the claimant is a legally competent individual. If the claimant is a legally incompetent individual, the Board may appoint the legal guardian or some other person as a representative payee.

(2) If payment is being made directly to a claimant and a question arises concerning his or her ability to manage or direct the management of benefit payments, the Board may, if the claimant has not been adjudged legally incompetent, continue to pay the claimant until the Board makes a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 348.2 Recognition by the Board of a person to act in behalf of another.

The provisions of part 266 of this chapter shall be applicable to the appointment of a representative payee under this part to the same extent and

in the same manner as they are applicable to the appointment of a representative payee under the Railroad Retirement Act.

PART 349—FINALITY OF DECISIONS REGARDING UNEMPLOYMENT AND SICKNESS INSURANCE BENEFITS

Sec.
349.1 Reopening and revising decisions.
349.2 Conditions for reopening.
349.3 Change of legal interpretation or administrative ruling.
349.4 Late completion of timely investigation.
349.5 Notice of revised decision.
349.6 Effect of revised decision.
349.7 Time and place to request a review and/or hearing on revised decision.
349.8 Discretion of the three-member Board to reopen or not to reopen a final decision.

AUTHORITY: 45 U.S.C. 355 and 362(l).

SOURCE: 65 FR 66499, Nov. 6, 2000, unless otherwise noted.

§ 349.1 Reopening and revising decisions.

(a) This part sets forth the Board's rules governing finality of decisions with respect to benefits under the Railroad Unemployment Insurance Act. After the expiration of the time limits for review as set forth in part 320 of this chapter, decisions may be reopened and revised only under the conditions described in this subpart, by the bureau, office or entity that made the earlier decision or by a bureau, office, or other entity at a higher level which has the claim properly before it. Whether a final decision is reopened or not reopened is solely within the discretion of the Board.

(b) A *final decision*, as that term is used in this part, means any decision under § 320.5 of this chapter where the time limit for review, as set forth in part 320 of this chapter or in the Railroad Unemployment Insurance Act, has expired.

(c) *Reopening* a final decision under this part means a conscious determination on the part of the agency to reconsider an otherwise final decision for purposes of revising that decision.

(d) *New and material evidence*, as that phrase is used in this part, means evidence which was unavailable to the agency at the time the decision was made, and which the claimant could not reasonably have been expected to have submitted at that time.

§ 349.2 Conditions for reopening.

A final decision may be reopened:

(a) Within 12 months of the date of the notice of such decision, for any reason;

(b) Within four years of the date of the notice of such decision:

(1) If there is new and material evidence; or

(2) If the decision was not reasonably consistent with the evidence of record at the time of adjudication.

(c) At any time if:

(1) The decision was obtained by fraud or similar fault;

(2) The decision was that the claimant was not a qualified employee, and he or she is now qualified because compensation was credited to the employee's record of compensation in accordance with part 211 of this chapter:

(i) To correct errors apparent on the face of the compensation record;

(ii) To enter items transferred by the Social Security Administration which were credited under the Social Security Act when they should have been credited to the employee's railroad retirement compensation record; or

(iii) To correct errors made in the allocation of earnings to individuals or periods which would have made him or her a qualified employee at the time of the decision if the earnings had been credited to his or her earnings record at that time;

(3) The decision is wholly or partially unfavorable to a claimant, but only to correct a clerical error or an error that appears on the face of the evidence that was considered when the decision was made.

§ 349.3 Change of legal interpretation or administrative ruling.

A change of legal interpretation or administrative ruling upon which a decision is based does not render a decision erroneous and does not provide a basis for reopening.

§ 349.4 Late completion of timely investigation.

(a) A decision may be revised after the applicable time period in §§ 349.2(a) or (b) expires if the Board begins an investigation into whether to revise the decision before the applicable time period expires and the agency diligently pursues the investigation to the conclusion. The investigation may be based on a request by a claimant or on action by the Board.

(b) *Diligently pursued* for purposes of this section means that in view of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if the investigation is concluded and, if necessary, the decision is revised within six months from the date the investigation began.

(c) If the investigation is not diligently pursued to its conclusion, the decision will be revised if a revision is applicable and if it is favorable to the claimant. It will not be revised if it would be unfavorable to the claimant.

§ 349.5 Notice of revised decision.

(a) When a decision is revised, notice of the revision will be mailed to the parties to the decision at their last known address. The notice will state the basis for the revised decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a hearings officer or the three-member Board proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, all parties will be notified in writing of the proposed action. If a revised decision is issued by a hearings officer, any party may request that it be reviewed by the three-member Board, or the three-member Board may review the decision on its own initiative.

§ 349.6 Effect of revised decision.

A revised decision is binding unless:

(a) The revised decision is being reconsidered or appealed in accord with part 320 of this chapter;

(b) The three-member Board reviews the revised decision; or

(c) The revised decision is further revised consistent with this part.

§ 349.7 Time and place to request a review and/or hearing on revised decision.

A party to a revised decision may request, as appropriate, further review of the decision in accordance with the rules set forth in part 320 of this chapter. Further review or a hearing will be held according to the rules set forth in part 320 of this chapter.

§ 349.8 Discretion of the three-member Board to reopen or not to reopen a final decision.

In any case in which the three-member Board may deem proper, the Board may direct that any decision, which is otherwise subject to reopening under this part, shall not be reopened or direct that any decision, which is otherwise not subject to reopening under this part, shall be reopened.

SUBCHAPTER D—GARNISHMENT OF BENEFITS

PART 350—GARNISHMENT OF BENEFITS PAID UNDER THE RAILROAD RETIREMENT ACT, THE RAILROAD UNEMPLOYMENT INSURANCE ACT, AND UNDER ANY OTHER ACT ADMINISTERED BY THE BOARD

Sec.
350.1 Authorization for garnishment of benefits paid by the Board.
350.2 Definitions.
350.3 Procedure.
350.4 Exemptions.
350.5 Miscellaneous.

AUTHORITY: 15 U.S.C. 1673(b)(2); 42 U.S.C. 659, 661, and 662; and 45 U.S.C. 231f(b)(5) and 362(1).

§ 350.1 Authorization for garnishment of benefits paid by the Board.

(a) Annuities and accrued annuities payable under the Railroad Retirement Act, sickness and unemployment benefits payable under the Railroad Unemployment Insurance Act, and benefits payable under any other Act administered by the Board, are subject, in like manner and to the same extent as if the Board were a private person, to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments.

(b) Lump sums, other than accrued annuities, which are payable under the Railroad Retirement Act of 1974, such as those payable under sections 6(b)(1) and 6(c)(1) of that Act, are not subject to legal process as defined in this subchapter. However, an individual entitled to a benefit under section 6 of the Railroad Retirement Act of 1974 may assign the right to receive all or any part of that benefit.

(c) Except as authorized under paragraphs (a) and (b) of this section and part 295 of this chapter, no benefit paid by the Board shall be assignable or be subject to garnishment, attachment, or other legal process, nor shall the payment thereof be anticipated.

(d) In the absence of law to the contrary, it will be assumed that ''wages,'' ''earnings,'' and analogous terms referred to in relevant provisions of state law include payments made by a private person which are analogous to those paid by the Board.

[45 FR 28314, Apr. 29, 1980, as amended at 50 FR 12242, Mar. 28, 1985; 53 FR 35807, Sept. 15, 1988]

§ 350.2 Definitions.

(a) *Child support* means periodic payments of funds for the support and maintenance of a child or children; such term also includes attorney's fees, interest, and court costs, when and to the same extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accordance with applicable state law by a court of competent jurisdiction.

(b) *Alimony* means periodic payments of funds for the support and maintenance of a spouse or former spouse and, subject to and in accord with state law, includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs, when and to the extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accord with applicable State law by a court of competent jurisdiction. Alimony does not include any payment or transfer of property or of its value in compliance with any community property settlement, equitable distribution of property, or other division of property, nor does it include any payment to an estate.

(c) *Legal process* means any court order, summons, or other similar process, including administrative orders, in the nature of garnishment, which is directed to and the purpose of which is to compel the Board to make a payment from moneys which are otherwise payable to an individual, to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments. For purposes of this subchapter, legal process additionally includes assignments in lieu of garnishment, but only where

grounds for the issuance of legal process in the nature of garnishment exist. Such assignments are revocable.

(d) *Legal obligation* means an obligation to pay alimony or child support which is enforceable under appropriate state law.

[45FR 28314, Apr. 29, 1980, as amended at 53 FR 35807, Sept. 15, 1988]

§ 350.3 Procedure.

(a) Service of legal process brought for the enforcement of an individual's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, directed to the Deputy General Counsel of the Board, 844 Rush Street, Chicago, Illinois 60611, or by personal service upon the Deputy General Counsel.

(b) Where the Deputy General Counsel is effectively served with legal process relating to an individual's legal obligation to provide child support or to make alimony payments, he shall, as soon as possible and not later than 15 days after the date of effective service of such process, send written notice that such process has been so served, together with a copy thereof, to the individual whose moneys are affected thereby; and, if response to such process is required, shall respond within 30 days, or within such longer period as may be prescribed by state law, after the date effective service is made. These requirements do not apply in the case of an assignment in lieu of garnishment or an assignment of a portion, attributable to the existence of the annuitant's family members, of a railroad retirement annuity computed under the social security minimum guaranty provision of the Railroad Retirement Act.

(c) Included with the legal process issued to the Board should be the name of the individual against whom the legal obligation to provide child support or to make alimony payments is sought to be enforced and, if available, the individual's social security or railroad retirement number, the individual's address, and the type of benefit that the individual is receiving from the Board.

(d) Legal process which refers to a payment in terms of a percentage of some other amount must also refer to that payment in terms of a specific amount or amounts. In connection with any legal process which does not refer to a payment in terms of a specific amount or amounts, the Board may compute the amount or may comply with that portion of the legal process which specifies an amount or amounts and withhold compliance with the balance of the process pending clarification from the issuing court or from the party which procured that process.

[45 FR 28314, Apr. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 350.4 Exemptions.

(a) Unless a lower percentage or dollar amount limitation on garnishment is provided by applicable state or local law, the portion of any payment due to an individual which is subject to legal process to enforce any order for the support of any person shall not exceed 65 percent. Where the individual is supporting a spouse or dependent child, other than a spouse or child with respect to whose support that legal process is issued, the portion subject to legal process is reduced by 10 percent. Where the alimony or support arrearage is less than 12 weeks old, the portion subject to legal process is reduced by 5 percent. If a lower limitation is provided by applicable state or local law, then that lower limitation shall be applied.

(b) In the absence of some evidence to the contrary, it will be assumed that the defendant is not supporting a spouse or dependent child other than a spouse or child with respect to whose support the legal process is issued.

(c) In any case in which a recurring benefit payment is reduced, whether due to a recovery by the Board of an overpayment or for some other reason, below the rate at which it is ordinarily paid, any applicable exemptions shall be applied to the amount of the reduced benefit which is actually paid.

(d) For purposes of the applicability of exemptions, amounts deducted for medicare premiums must first be subtracted from the annuity amount.

[45 FR 28314, Apr. 29, 1980]

§ 350.5 Miscellaneous.

(a) The Board may not be required to vary its normal disbursement cycles in order to comply with legal process. However, legal process which is received too late to be honored during the disbursement cycle in which it is received may be honored to the extent that the legal process may, in compliance with this part, be satisfied from the next payment due to the obligor.

(b) Except as provided in these regulations, the Board may not be required in connection with proceedings under this part to forward documents which have been sent to the Board, to an individual, whether or not he is entitled to benefits paid by the Board, or to disclose information other than that relating to the type, amount (whether actual or estimated), and dates of payment of benefits paid by the Board to that individual.

(c) Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to legal process regular on its face, if such payment is made in accordance with this part.

(d) No employee of the Board whose duties include responding to legal process pursuant to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in responding to any such process.

(e) For purposes of a proceeding under this part, the Board will apply the law of the state in which the legal process is issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any state with significant interest in the matter.

(f) No acknowledgement or response will be made to legal process which does not contain the mailing address to which acknowledgement may be made. No response to any legal process will be notarized or verified.

[45 FR 28314, Apr. 29, 1980, as amended at 50 FR 12242, Mar. 28, 1985]

SUBCHAPTER E—ADMINISTRATIVE REMEDIES FOR FRAUDULENT CLAIMS OR STATEMENTS

PART 355—REGULATIONS UNDER THE PROGRAM FRAUD CIVIL REMEDIES ACT OF 1986

Sec.

355.1 Basis and purpose.
355.2 Definitions.
355.3 Basis for civil penalties and assessments.
355.4 Investigation.
355.5 Review by the reviewing official.
355.6 Prerequisites for issuing a complaint.
355.7 Complaint.
355.8 Service of complaint.
355.9 Answer.
355.10 Default upon failure to file an answer.
355.11 Referral of complaint and answer to the ALJ.
355.12 Notice of hearing.
355.13 Parties to the hearing.
355.14 Separation of functions.
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355.16 Disqualification of reviewing official or ALJ.
355.17 Rights of parties.
355.18 Authority of the ALJ.
355.19 Prehearing conferences.
355.20 Disclosure of documents.
355.21 Discovery.
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355.23 Subpoenas for attendance at hearing.
355.24 Protective order.
355.25 Fees.
355.26 Form, filing and service of papers.
355.27 Computation of time.
355.28 Motions.
355.29 Sanctions.
355.30 The hearing and burden of proof.
355.31 Determining the amount of penalties and assessments.
355.32 Location of hearing.
355.33 Witnesses.
355.34 Evidence.
355.35 The record.
355.36 Post-hearing briefs.
355.37 Initial decision.
355.38 Reconsideration of initial decision.
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355.40 Stays ordered by the Department of Justice.
355.41 Stay pending appeal.
355.42 Judicial review.
355.43 Collection of civil penalties and assessments.
355.44 Right to administrative offset.
355.45 Deposit in Treasury of United States.
355.46 Compromise or settlement.
355.47 Limitations.

AUTHORITY: 31 U.S.C. 3809.

SOURCE: 52 FR 47706, Dec. 16, 1987, unless otherwise noted.

§ 355.1 Basis and purpose.

(a) *Basis.* This part implements the Program Fraud Civil Remedies Act of 1986, Pub. L. 99–509, 6101–6104, 100 Stat. 1874 (Oct. 21, 1986), to be codified at 31 U.S.C. 3801–3812. 31 U.S.C. 3809 of the statute requires each authority head to promulgate regulations necessary to implement the provisions of the statute.

(b) *Purpose.* This part—

(1) Establishes administrative procedures for imposing civil penalties and assessments against persons who make, submit, or present, or cause to be made, submitted, or presented, false, fictitious, or fraudulent claims or written statements to authorities or to their agents, and

(2) Specifies the hearing and appeal rights of persons subject to allegations of liability for such penalties and assessments.

§ 355.2 Definitions.

ALJ means an Administrative Law Judge detailed to the authority pursuant to 5 U.S.C. 3344.

Authority means Railroad Retirement Board.

Authority head means the three-member Railroad Retirement Board.

Benefits means, except as the context otherwise requires, anything of value, including but not limited to any advantage, preference, privilege, license, permit, favorable decision, ruling, status, or loan guarantee.

Board means Railroad Retirement Board.

Claim means any request, demand, or submission—

(a) Made to the authority for property, services, or money (including money representing grants, loans, insurance, or benefits);

(b) Made to a recipient of property, services, or money from the authority or to a party to a contract with the authority—

(1) For property or services if the United States—

(i) Provided such property or services;

(ii) Provided any portion of the funds for the purchase of such property or services; or

(iii) Will reimburse such recipient or party for the purchase of such property or services; or

(2) For the payment of money (including money representing grants, loans, insurance, or benefits) if the United States—

(i) Provided any portion of the money requested or demanded; or

(ii) Will reimburse such recipient or party for any portion of the money paid on such request or demand; or

(c) Made to the authority which has the effect of decreasing an obligation to pay or account for property, services, or money.

Complaint means the administrative complaint served by the reviewing official on the defendant under § 355.7.

Defendant means any person alleged in a complaint under § 355.7 to be liable for a civil penalty or assessment under § 355.3.

Government means the U.S. Government.

Individual means a natural person.

Initial decision means the written decision of the ALJ required by § 355.10 or § 355.37, and includes a revised initial decision issued following a remand or a motion for reconsideration.

Investigating official means the Inspector General of the Railroad Retirement Board or an officer or employee of the Office of the Inspector General designated by the Inspector General and serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule.

Knows or has reason to know means that a person, with respect to a claim or statement—

(a) Has actual knowledge that the claim or statement is false, fictitious, or fraudulent;

(b) Acts in deliberate ignorance of the truth or falsity of the claim or statement; or

(c) Acts in reckless disregard of the truth or falsity of the claim or statement.

Makes, wherever it appears, shall include the terms presents, submits, and causes to be made, presented, or submitted. As the context requires, *making* or *made* shall likewise include the corresponding forms of such terms.

Person means any individual, partnership, corporation, association, private organization, state, political subdivision of a state, municipality, county, district, and Indian tribe, and includes the plural of that term.

Presiding officer means ALJ.

Representative means an attorney who is a member in good standing of the bar of any state, territory, or possession of the United States or of the District of Columbia.

Reviewing official means the General Counsel of the Board or his or her designee who is—

(a) Not subject to supervision by, or required to report to, the investigating official; and

(b) Not employed in the organizational unit of the authority in which the investigating official is employed; and

(c) Is serving in a position for which the rate of basic pay is not less than the minimum rate of basic pay for grade GS–16 under the General Schedule.

Statement means any representation, certification, affirmation, document, record, or accounting or bookkeeping entry made—

(a)With respect to a claim or to obtain the approval or payment of a claim (including relating to eligibility to make a claim); or

(b) With respect to (including relating to eligibility for)—

(1) A contract with, or a bid or proposal for a contract with; or

(2) A grant, loan, or benefit from the authority, or any state, political subdivision of a state, or other party, if the U.S. Government provides any portion of the money or property under such contract or for such grant, loan, or benefit, or if the Government will reimburse such state, political subdivision, or party for any portion of the money or property under such contract or for such grant, loan, or benefit.

§ 355.3 Basis for civil penalties and assessments.

(a) *Claims.* (1) Except as provided in paragraph (c) of this section, any person who makes a claim that the person knows or has reason to know—

(i) Is false, fictitious, or fraudulent;

(ii) Includes or is supported by any written statement which asserts a material fact which is false, fictitious, or fraudulent;

(iii) Includes or is supported by any written statement that—

(A) Omits a material fact;

(B) Is false, fictitious, or fraudulent as a result of such omission; and

(C) Is a statement in which the person making such statement has a duty to include such material fact; or

(iv) Is for payment for the provision of property or services which the person has not provided as claimed, shall be subject, in addition to any other remedy that may be prescribed by law, to a civil penalty of not more than $5,000 for each such claim. This penalty is subject to adjustment in accord with part 356 of this chapter.

(2) Each voucher, invoice, claim form, or other individual request or demand for property, services, or money constitutes a separate claim.

(3) A claim shall be considered made to an authority, recipient, or party when such claim is actually made to an agent, fiscal intermediary, or other entity, including any state or political subdivision thereof, acting for or on behalf of such authority, recipient, or party.

(4) Each claim for property, services, or money is subject to a civil penalty regardless of whether such property, services, or money is actually delivered or paid.

(5) If the Government has made any payment (including transferred property or provided services) on a claim, a person subject to a civil penalty under paragraph (a)(1) of this section shall also be subject to an assessment of not more than twice the amount of such claim or that portion thereof that is determined to be in violation of paragraph (a)(1) of this section. Such assessment shall be in lieu of damages sustained by the Government because of such claim. However, such assessment shall not be in lieu of any recovery of erroneous payments as authorized by section 10 of the Railroad Retirement Act or section 2(d) of the Railroad Unemployment Insurance Act.

(b) *Statements.* (1) Except as provided in paragraph (c) of this section, any person who makes a written statement that—

(i) The person knows or has reason to know—

(A) Asserts a material fact which is false, fictitious, or fraudulent; or

(B) Is false, fictitious, or fraudulent because it omits a material fact that the person making the statement has a duty to include in such statement; and

(ii) Contains or is accompanied by an express certification or affirmation of the truthfulness and accuracy of the contents of the statement, shall be subject, in addition to any other remedy that may be prescribed by law, to a civil penalty of not more than $5,000 for each such statement. This penalty is subject to adjustment in accord with part 356 of this chapter.

(2) Each written representation, certification, or affirmation constitutes a separate statement.

(3) A statement shall be considered made to an authority when such statement is actually made to an agent, fiscal intermediary, or other entity, including any state or political subdivision thereof, acting for or behalf of such authority.

(c)(1) In the case of any claim or statement made by any individual relating to any of the benefits listed in paragraph (c)(2) of this section received by such individual, such individual may be held liable for penalties and assessments under this section only if such claim or statement is made by such individual in making application for such benefits with respect to such individual's eligibility to receive such benefits.

(2) For purposes of this paragraph, the term ''benefits'' means any annuity or other benefit under the Railroad Retirement Act of 1974 which are intended for the personal use of the individual who receives the benefits or for a member of the individual's family.

(d) No proof of specific intent to defraud is required to establish liability under this section.

(e) In any case in which it is determined that more than one person is liable for making a claim or statement under this section, each such person may be held liable for a civil penalty under this section.

(f) In any case in which it is determined that more than one person is liable for making a claim under this section on which the Government has made payment (including transferred property or provided services), an assessment may be imposed against any such person or jointly and severally against any combination of such persons.

[52 FR 47706, Dec. 16, 1987, as amended at 62 FR 3791, Jan. 27, 1997]

§ 355.4 Investigation.

(a) If an investigating official concludes that a subpoena pursuant to the authority conferred by 31 U.S.C. 3804(a) is warranted—

(1) The subpoena so issued shall notify the person to whom it is addressed of the authority under which the subpoena is issued and shall identify the records or documents sought;

(2) He or she may designate a person to act on his behalf to receive the documents sought; and

(3) The person receiving such subpoena shall be required to tender to the investigating official or the person designated to receive the documents a certification that the documents sought have been produced, or that such documents are not available and the reasons therefor, or that such documents, suitably identified, have been withheld based upon the assertion of an identified privilege.

(b) If the investigating official concludes that an action under the Program Fraud Civil Remedies Act may be warranted, the investigating official shall submit a report containing the findings and conclusions of such investigation to the reviewing official.

(c) Nothing in this section shall preclude or limit an investigating official's discretion to refer allegations directly to the Department of Justice for suit under the False Claims Act or other civil relief, or to preclude or limit such official's discretion to defer or postpone a report or referral to avoid interference with a criminal investigation or prosecution.

(d) Nothing in this section modifies any responsibility of an investigating official to report violations of criminal law to the Attorney General.

§ 355.5 Review by the reviewing official.

(a) If, based on the report of the investigating official under § 355.4(b), the reviewing official determines that there is adequate evidence to believe that a person is liable under § 355.3 of this part, the reviewing official shall transmit to the Attorney General a written notice of the reviewing official's intention to issue a complaint under § 355.7.

(b) Such notice shall include—

(1) A statement of the reviewing official's reasons for issuing a complaint;

(2) A statement specifying the evidence that supports the allegations of liability;

(3) A description of the claims or statements upon which the allegations of liability are based;

(4) An estimate of the amount of money or the value of property, services, or other benefits requested or demanded in violation of § 355.3 this part;

(5) A statement of any exculpatory or mitigating circumstances that may relate to the claims or statements known by the reviewing official or the investigating official; and

(6) A statement that there is a reasonable prospect of collecting an appropriate amount of penalties and assessments. Such a statement may be based upon information then known or an absence of any information indicating that the person may be unable to pay such an amount.

§ 355.6 Prerequisites for issuing a complaint.

(a) The reviewing official may issue a complaint under § 355.7 only if—

(1) The Department of Justice approves the issuance of a complaint in a written statement described in 31 U.S.C. 3803(b)(1), and

(2) In the case of allegations of liability under § 355.3(a) with respect to a claim, the reviewing official determines that, with respect to such claim or a group of related claims submitted

at the same time such claim is submitted (as defined in paragraph (b) of this section), the amount of money or the value of property or services demanded or requested in violation of § 355.3(a) does not exceed $150,000.

(b) For the purposes of this section, a related group of claims submitted at the same time shall include only those claims arising from the same transaction (*e.g.*, grant, loan, application, or contract) that are submitted simultaneously as part of a single request, demand, or submission.

(c) Nothing in this section shall be construed to limit the reviewing official's authority to join in a single complaint against a person, claims that are unrelated or were not submitted simultaneously, regardless of the amount of money or the value of property or services demanded or requested.

§ 355.7 Complaint.

(a) On or after the date the Department of Justice approves the issuance of a complaint in accordance with 31 U.S.C. 3803(b)(1), the reviewing official may serve a complaint on the defendant, as provided in § 355.8.

(b) The complaint shall state—

(1) The allegations of liability against the defendant, including the statutory basis for liability, an identification of the claims or statements that are the basis for the alleged liability, and the reasons why liability allegedly arises from such claims or statements;

(2) The maximum amount of penalties and assessments for which the defendant may be held liable;

(3) Instructions for filing an answer to request a hearing, including a specific statement of the defendant's right to request a hearing by filing an answer and to be represented by a representative; and

(4) That failure to file and answer within 30 days of service of the complaint may result in the imposition of the maximum amount of penalties and assessments without right to appeal.

(c) At the same time the reviewing official serves the complaint, he or she shall serve the defendant with a copy of these regulations.

§ 355.8 Service of complaint.

(a) Service of a complaint must be made by certified or registered mail or by delivery in any manner authorized by Rule 4(d) of the Federal Rules of Civil Procedure.

(b) Proof of service, stating the name and address of the person on whom the complaint was served, and the manner and date of service, may be made by—

(1) Affidavit of the individual making service;

(2) An acknowledged U.S. Postal Service return receipt card; or

(3) Written acknowledgment of the defendant or his representative.

§ 355.9 Answer.

(a) The defendant may request a hearing by filing an answer with the reviewing official within 30 days of service of the complaint. An answer shall be deemed to be a request for hearing.

(b) In the answer, the defendant—

(1) Shall admit or deny each of the allegations of liability made in the complaint;

(2) Shall state any defense on which the defendant intends to rely;

(3) May state any reasons why the defendant contends that the penalties and assessments should be less than the statutory maximum; and

(4) Shall state the name, address, and telephone number of the person authorized by the defendant to act as defendant's representative, if any.

§ 355.10 Default upon failure to file an answer.

(a) If the defendant does not file an answer within the time prescribed in § 355.9(a), the reviewing official may refer the complaint to the ALJ.

(b) Upon the referral of the complaint, the ALJ shall promptly serve on defendant in the manner prescribed in § 355.8, a notice that an initial decision will be issued under this section.

(c) If the defendant has failed to answer the complaint, the ALJ shall assume the facts alleged in the complaint to be true and, if such facts establish liability under § 355.3, the ALJ shall issue an initial decision imposing the maximum amount of penalties and assessments allowed under the statute.

(d) Except as otherwise provided in this section, by failing to file a timely answer, the defendant waives any right to further review of the penalties and assessments imposed under paragraph (c) of this section, and the initial decision shall become final and binding upon the parties 30 days after it is issued.

(e) If, before such an initial decision becomes final, the defendant files a motion with the ALJ seeking to reopen on the grounds that extraordinary circumstances prevented the defendant from filing an answer, the initial decision shall be stayed pending the ALJ's decision on the motion.

(f) If, on such motion, the defendant can demonstrate extraordinary circumstances excusing the failure to file a timely answer, the ALJ shall withdraw the initial decision in paragraph (c) of this section, if such a decision has been issued, and shall grant the defendant an opportunity to answer the complaint.

(g) A decision of the ALJ denying a defendant's motion under paragraph (e) of this section is not subject to reconsideration under § 355.38.

(h) The defendant may appeal to the authority head the decision denying a motion to reopen by filing a notice of appeal with the authority head within 15 days after the ALJ denies the motion. The timely filing of a notice of appeal shall stay the initial decision until the authority head decides the issue.

(i) If the defendant files a timely notice of appeal with the authority head, the ALJ shall forward the record of the proceeding to the authority head.

(j) The authority head shall decide expeditiously whether extraordinary circumstances excuse the defendant's failure to file a timely answer based solely on the record before the ALJ.

(k) If the authority head decides that extraordinary circumstances excused the defendant's failure to file a timely answer, the authority head shall remand the case to the ALJ with instructions to grant the defendant an opportunity to answer.

(l) If the authority head decides that the defendant's failure to file a timely answer is not excused, the authority head shall reinstate the initial decision of the ALJ, which shall become final and binding upon the parties 30 days after the authority head issues such decision.

§ 355.11 Referral of complaint and answer to the ALJ.

Upon receipt of an answer, the reviewing official shall file the complaint and answer with the ALJ.

§ 355.12 Notice of hearing.

(a) When the ALJ receives the complaint and answer, the ALJ shall promptly serve a notice of hearing upon the defendant in the manner prescribed by § 355.8. At the same time, the ALJ shall send a copy of such notice to the representative for the Government.

(b) Such notice shall include—

(1) The tentative time and place, and the nature of the hearing;

(2) The legal authority and jurisdiction under which the hearing is to be held;

(3) The matters of fact and law to be asserted;

(4) A description of the procedures for the conduct of the hearing;

(5) The name, address, and telephone number of the representative of the Government and of the defendant, if any; and

(6) Such other matters as the ALJ deems appropriate.

§ 355.13 Parties to the hearing.

(a) The parties to the hearing shall be the defendant and the authority.

(b) Pursuant to 31 U.S.C. 3730(c)(5), a private plaintiff under the False Claims Act may participate in these proceedings to the extent authorized by the provisions of that Act.

§ 355.14 Separation of functions.

(a) The investigating official, the reviewing official, and any employee or agent of the authority who takes part in investigating, preparing, or presenting a particular case may not, in such case or a factually related case—

(1) Participate in the hearing as the ALJ;

(2) Participate or advise in the initial decision or the review of the initial decision by the authority head, except as a witness or a representative in public proceedings; or

(3) Make the collection of penalties and assessments under 31 U.S.C. 3806.

(b) The ALJ shall not be responsible to, or subject to the supervision or direction of the investigating official or the reviewing official.

(c) Except as provided in paragraph (a) of this section, the representative for the Government may be employed anywhere in the authority, including in the offices of either the investigating official or the reviewing official.

§ 355.15 Ex parte contacts.

No party or person (except employees of the ALJ's office) shall communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

§ 355.16 Disqualification of reviewing official or ALJ.

(a) A reviewing official or ALJ in a particular case may disqualify himself or herself at any time.

(b) A party may file with the ALJ a motion for disqualification of a reviewing official or an ALJ. Such motion shall be accompanied by an affidavit alleging personal bias or other reason for disqualification.

(c) Such motion and affidavit shall be filed promptly upon the party's discovery of reasons requiring disqualification, or such objections shall be deemed waived.

(d) Such affidavit shall state specific facts that support the party's discovery of such facts. It shall be accompanied by a certificate of the representative of record that it is made in good faith.

(e) Upon the filing of such a motion and affidavit, the ALJ shall proceed no further in the case until he or she resolves the matter of disqualification in accordance with paragraph (f) of this section.

(f)(1) If the ALJ determines that a reviewing official is disqualified, the ALJ shall dismiss the complaint without prejudice.

(2) If the ALJ disqualifies himself or herself, the case shall be reassigned promptly to another ALJ.

(3) If the ALJ denies a motion to disqualify, the authority head may determine the matter only as part of his or her review of the initial decision upon appeal, if any.

§ 355.17 Rights of parties.

Except as otherwise limited by this part, all parties may—

(a) Be accompanied, represented, and advised by a representative;

(b) Participate in any conference held by the ALJ;

(c) Conduct discovery;

(d) Agree to stipulations of fact or law, which shall be made part of the record;

(e) Present evidence relevant to the issues at the hearing;

(f) Present and cross-examine witnesses;

(g) Present oral arguments at the hearing as permitted by the ALJ; and

(h) Submit written briefs and proposed findings of fact and conclusions of law after the hearing.

§ 355.18 Authority of the ALJ.

(a) The ALJ shall conduct a fair and impartial hearing, avoid delay, maintain order, and assure that a record of the proceeding is made.

(b) The ALJ has the authority to—

(1) Set and change the date, time, and place of the hearing upon reasonable notice to the parties;

(2) Continue or recess the hearing in whole or in part for a reasonable period of time;

(3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(4) Administer oaths and affirmations;

(5) Issue subpoenas requiring the attendance of witnesses and the production of documents at depositions or at hearings;

(6) Rule on motions and other procedural matters;

(7) Regulate the scope and timing of discovery;

(8) Regulate the course of the hearing and the conduct of representatives and parties;

(9) Examine witnesses;

(10) Receive, rule on, exclude, or limit evidence;

(11) Upon motion of a party, take official notice of facts;

(12) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact;

(13) Conduct any conference, argument, or hearing on motions in person or by telephone; and

(14) Exercise such other authority as is necessary to carry out the responsibilities of the ALJ under this part.

(c) The ALJ does not have the authority to decide upon the validity of Federal statutes or regulations.

§ 355.19 Prehearing conferences.

(a) The ALJ may schedule prehearing conferences as appropriate.

(b) Upon the motion of any party, the ALJ shall schedule at least one prehearing conference at a reasonable time in advance of the hearing.

(c) The ALJ may use prehearing conferences to discuss the following:

(1) Simplification of the issues;

(2) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement;

(3) Stipulations, admissions of fact or as to the contents and authenticity of documents;

(4) Whether the parties can agree to submission of the case on a stipulated record;

(5) Whether a party chooses to waive appearance at an oral hearing and to submit only documentary evidence (subject to the objection of other parties) and written argument;

(6) Limitation of the number of witnesses;

(7) Scheduling dates for the exchange of witness lists and of proposed exhibits;

(8) Discovery;

(9) The time and place for the hearing; and

(10) Such other matters as may tend to expedite the fair and just disposition of the proceedings.

(d) The ALJ may issue an order containing all matters agreed upon by the parties or ordered by the ALJ at a prehearing conference.

§ 355.20 Disclosure of documents.

(a) Upon written request to the reviewing official, the defendant may review any relevant and material documents, transcripts, records, and other materials that relate to the allegations set out in the complaint and upon which the findings and conclusions of the investigating official under § 355.4(b) are based unless such documents are subject to a privilege under Federal law. Upon payment of fees for duplication, the defendant may obtain copies of such documents.

(b) Upon written request to the reviewing official, the defendant also may obtain a copy of all exculpatory information in the possession of the reviewing official or investigating official relating to the allegations in the complaint, even if it is contained in a document that would otherwise be privileged. If the document would otherwise be privileged, only that portion containing exculpatory information must be disclosed.

(c) The notice sent to the Attorney General from the reviewing official as described in § 355.5 is not discoverable under any circumstances.

(d) The defendant may file a motion to compel disclosure of the documents subject to the provisions of this section. Such a motion may only be filed with the ALJ following the filing of an answer pursuant to § 355.9.

§ 355.21 Discovery.

(a) The following types of discovery are authorized:

(1) Requests for production of documents for inspection and copying;

(2) Requests for admissions of the authenticity of any relevant document or of the truth of any relevant fact;

(3) Written interrogatories; and

(4) Depositions.

(b) For the purpose of this section and §§ 355.22 and 355.23, the term ''documents'' includes information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence. Nothing contained herein shall be interpreted to require the creation of a document.

(c) Unless mutually agreed to by the parties, discovery is available only as ordered by the ALJ. The ALJ shall regulate the timing of discovery.

(d) *Motions for discovery.* (1) A party seeking discovery may file a motion with the ALJ. Such a motion shall be accompanied by a copy of the requested discovery, or in the case of depositions, a summary of the scope of the proposed deposition.

(2) Within ten days of service, a party may file an opposition to the motion and/or a motion for protective order as provided in § 355.24.

(3) The ALJ may grant a motion for discovery only if he or she finds that the discovery sought—

(i) Is necessary for the expeditious, fair, and reasonable consideration of the issues;

(ii) Is not unduly costly or burdensome;

(iii) Will not unduly delay the proceeding; and

(iv) Does not seek privileged information.

(4) The burden of showing that discovery should be allowed is on the party seeking discovery.

(5) The ALJ may grant discovery subject to a protective order under § 355.24.

(e) *Depositions.* (1) If a motion for deposition is granted, the ALJ shall issue a subpoena for the deponent, which may require the deponent to produce documents. The subpoena shall specify the time and place at which the deposition will be held.

(2) The party seeking to depose shall serve the subpoena in the manner prescribed in § 355.8.

(3) The deponent may file with the ALJ a motion to quash the subpoena or a motion for a protective order within ten days of service.

(4) The party seeking to depose shall provide for the taking of a verbatim transcript of the deposition, which it shall make available to all other parties for inspection and copying.

(f) Each party shall bear its own costs of discovery.

§ 355.22 Exchange of witness lists, statements, and exhibits.

(a) At least 15 days before the hearing or at such other time as may be ordered by the ALJ, the parties shall exchange witness lists, copies of prior statements of proposed witnesses, and copies of proposed hearing exhibits, including copies of any written statements that the party intends to offer in lieu of live testimony in accordance with § 355.33(b). At the time the above documents are exchanged, any party that intends to rely on the transcript of deposition testimony in lieu of live testimony at the hearing, if permitted by the ALJ, shall provide each party with a copy of the specific pages of the transcript it intends to introduce into evidence.

(b) If a party objects, the ALJ shall not admit into evidence the testimony of any witness whose name does not appear on the witness list or any exhibit not provided to the opposing party as provided above unless the ALJ finds good cause for the failure or that there is no prejudice to the objecting party.

(c) Unless another party objects within the time set by the ALJ, documents exchanged in accordance with paragraph (a) of this section shall be deemed to be authentic for the purpose of admissibility at the hearing.

§ 355.23 Subpoenas for attendance at hearing.

(a) A party wishing to procure the appearance and testimony of any individual at the hearing may request that the ALJ issue a subpoena.

(b) A subpoena requiring the attendance and testimony of an individual may also require the individual to produce documents at the hearing.

(c) A party seeking a subpoena shall file a written request therefor not less than 15 days before the date fixed for the hearing unless otherwise allowed by the ALJ for good cause shown. Such request shall specify any documents to be produced and shall designate the witnesses and describe the address and location thereof with sufficient particularity to permit such witnesses to be found.

(d) The subpoena shall specify the time and place at which the witness is to appear and any documents the witness is to produce.

(e) The party seeking the subpoena shall serve it in the manner prescribed in § 355.8. A subpoena on a party or upon an individual under the control of a party may be served by first-class mail.

(f) A party or the individual to whom the subpoena is directed may file with

the ALJ a motion to quash the subpoena within ten days after service or on or before the time specified in the subpoena for compliance if it is less than ten days after service.

§ 355.24 Protective order.

(a) A party or a prospective witness or deponent may file a motion for a protective order with respect to discovery sought by an opposing party or with respect to the hearing, seeking to limit the availability or disclosure of evidence.

(b) In issuing a protective order, the ALJ may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following:

(1) That the discovery not be had;

(2) That the discovery may be had only on specified terms and conditions, including a designation of the time or place;

(3) That the discovery may be had only through a method of discovery other than that requested;

(4) That certain matters not be inquired into, or that the scope of discovery be limited to certain matters;

(5) That discovery be conducted with no one present except persons designated by the ALJ;

(6) That the contents of discovery or evidence be sealed;

(7) That a deposition after being sealed be opened only by order of the ALJ;

(8) That a trade secret or other confidential research, development, commercial information, or facts pertaining to any criminal investigation, proceeding, or other administrative investigation not be disclosed or be disclosed only in a designated way; or

(9) That the parties simultaneously file specified documents or information enclosed in sealed envelopes to be opened as directed by the ALJ.

§ 355.25 Fees.

The party requesting a subpoena shall pay the cost of the fees and mileage of any witness subpoenaed in the amounts that would be payable to a witness in a proceeding in U.S. District Court. A check for witness fees and mileage shall accompany the subpoena when served, except that when a subpoena is issued on behalf of the authority, a check for witness fees and mileage need not accompany the subpoena.

§ 355.26 Form, filing and service of papers.

(a) *Form.* (1) Documents filed with the ALJ shall include an original and two copies.

(2) Every pleading and paper filed in the proceeding shall contain a caption setting forth the title of the action, the case number assigned by the ALJ, and a designation of the paper (*e.g.*, motion to quash subpoena).

(3) Every pleading and paper shall be signed by, and shall contain the address and telephone number of the party or the person on whose behalf the paper was filed, or his or her representative.

(4) Papers are considered filed when they are mailed. Date of mailing may be established by a certificate from the party or its representative or by proof that the document was sent by certified or registered mail.

(b) *Service.* A party filing a document with the ALJ shall, at the time of filing, serve a copy of such document on every other party. Service upon any party of any document other than the complaint or notice of hearing shall be made by delivering or mailing a copy to the party's last known address. When a party is represented by a representative, service shall be made upon such representative in lieu of the actual party.

(c) *Proof of service.* A certificate of the individual serving the document by personal delivery or by mail, setting forth the manner of service, shall be proof of service.

§ 355.27 Computation of time.

(a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event, or default, and includes the last day of the period, unless it is a Saturday, Sunday, or legal holiday observed by the Federal government, in which event it includes the next business day.

(b) When the period of time allowed is less than seven days, intermediate Saturdays, Sundays, and legal holidays

observed by the Federal government shall be excluded from the computation.

(c) Where a document has been served or issued by mail, an additional five days will be added to the time permitted for any response.

§ 355.28 Motions.

(a) Any application to the ALJ for an order or ruling shall be by motion. Motions shall state the relief sought, the authority relied upon, and the facts alleged, and shall be filed with the ALJ and served on all other parties.

(b) Except for motions made during a prehearing conference or at the hearing, all motions shall be in writing. The ALJ may require that oral motions be reduced to writing.

(c) Within 15 days after a written motion is served, or such other time as may be fixed by the ALJ, any party may file a response to such motion.

(d) The ALJ may not grant a written motion before the time for filing responses thereto has expired, except upon consent of the parties or following a hearing on the motion, but may overrule or deny such motion without awaiting a response.

(e) The ALJ shall make a reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

§ 355.29 Sanctions.

(a) The ALJ may sanction a person, including any party or representative for—

(1) Failing to comply with an order, rule, or procedure governing the proceeding;

(2) Failing to prosecute or defend an action; or

(3) Engaging in other misconduct that interferes with the speedy, orderly, or fair conduct of the hearing.

(b) Any such sanction, including but not limited to those listed in paragraphs (c), (d), (e) of this section, shall reasonably relate to the severity and nature of the failure or misconduct.

(c) When a party fails to comply with an order, including an order for taking a deposition, the production of evidence within the party's control, or a request for admission, the ALJ may—

(1) Draw an inference in favor of the requesting party with regard to the information sought;

(2) In the case of requests for admission, deem each matter of which an admission is requested to be admitted;

(3) Prohibit the party failing to comply with such order from introducing evidence concerning, or otherwise relying upon testimony relating to the information sought; and

(4) Strike any part of the pleadings or other submissions of the party failing to comply with such request.

(d) If a party fails to prosecute or defend an action under this part commenced by service of a notice of hearing, the ALJ may dismiss the action or may issue an initial decision imposing penalties and assessments.

(e) The ALJ may refuse to consider any motion, request, response, brief or other document which is not filed in a timely fashion.

§ 355.30 The hearing and burden of proof.

(a) The ALJ shall conduct a hearing on the record in order to determine whether the defendant is liable for a civil penalty or assessment under § 355.3 and, if so, the appropriate amount of any such civil penalty or assessment considering any aggravating or mitigating factors.

(b) The authority shall prove defendant's liability and any aggravating factors by a preponderance of the evidence.

(c) The defendant shall prove any affirmative defenses and any mitigating factors by a preponderance of the evidence.

(d) The hearing shall be open to the public unless otherwise ordered by the ALJ for good cause shown.

§ 355.31 Determining the amount of penalties and assessments.

(a) In determining an appropriate amount of civil penalties and assessments, the ALJ and upon appeal, the authority head, should evaluate any circumstances that mitigate or aggravate the violation and should articulate in their opinions the reasons that support the penalties and assessments they impose. Because of the intangible

costs of fraud, the expense of investigating such conduct, and the need to deter others who might be similarly tempted, ordinarily double damages and a significant civil penalty should be imposed.

(b) Although not exhaustive, the following factors are among those that may influence the ALJ and the authority head in determining the amount of penalties and assessments to impose with respect to the misconduct (*i.e.*, the false, fictitious, or fraudulent claims or statements) charged in the complaint:

(1) The number of false, fictitious, or fraudulent claims or statements;

(2) The time period over which such claims or statements were made;

(3) The degree of the defendant's culpability with respect to the misconduct;

(4) The amount of money or the value of the property, services, or benefit falsely claimed;

(5) The value of the Government's actual loss as a result of the misconduct, including foreseeable consequential damages and the costs of investigation;

(6) The relationship of the amount imposed as civil penalties to the amount of the Government's loss;

(7) The potential or actual impact of the misconduct upon national defense, public health or safety, or public confidence in the management of Government programs and operations, including particularly the impact on the intended beneficiaries of such programs;

(8) Whether the defendant has engaged in a pattern of the same or similar misconduct;

(9) Whether the defendant attempted to conceal the misconduct;

(10) The degree to which the defendant has involved others in the misconduct or in concealing it;

(11) Where the misconduct of employees or agents is imputed to the defendant, the extent to which the defendant's practices fostered or attempted to preclude such misconduct;

(12) Whether the defendant cooperated in or obstructed an investigation of the misconduct;

(13) Whether the defendant assisted in identifying and prosecuting other wrongdoers;

(14) The complexity of the program or transaction, and the degree of the defendant's sophistication with respect to it, including the extent of the defendant's prior participation in the program or in similar transactions;

(15) Whether the defendant has been found, in any criminal, civil, or administrative proceeding to have engaged in similar misconduct or to have dealt dishonestly with the Government of the United States or of a state, directly or indirectly; and

(16) The need to deter the defendant and others from engaging in the same or similar misconduct.

(c) Nothing in this section shall be construed to limit the ALJ or the authority head from considering any other factors that in any given case may mitigate or aggravate the offense for which penalties and assessments are imposed.

§ 355.32 Location of hearing.

(a) The hearing may be held—

(1) In any judicial district of the United States in which the defendant resides or transacts business;

(2) In any judicial district of the United States in which the claim or statement in issue was made; or

(3) In such other place as may be agreed upon by the defendant and the ALJ.

(b) Each party shall have the opportunity to present argument with respect to the location of the hearing.

(c) The hearing shall be held at the place and at the time ordered by the ALJ.

§ 355.33 Witnesses.

(a) Except as provided in paragraph (b) of this section, testimony at the hearing shall be given orally by witnesses under oath or affirmation.

(b) At the discretion of the ALJ, testimony may be admitted in the form of a written statement or deposition. Any such written statement must be provided to all other parties along with the last known address of such witness, in a manner which allows sufficient time for other parties to subpoena such witness for cross-examination at the hearing. Prior written statements of witnesses proposed to testify at the hearing and deposition transcripts

shall be exchanged as provided in § 355.22(a).

(c) The ALJ shall exercise reasonable control over the mode and order of interrogating witnesses and presenting evidence so as to—

(1) Make the interrogation and presentation effective for the ascertainment of the truth.

(2) Avoid needless consumption of time, and

(3) Protect witnesses from harassment or undue embarrassment.

(d) The ALJ shall permit the parties to conduct such cross-examination as may be required for a full and true disclosure of the facts.

(e) At the discretion of the ALJ, a witness may be cross-examined on matters relevant to the proceeding without regard to the scope of his or her direct examination. To the extent permitted by the ALJ, cross-examination on matters outside the scope of direct examination shall be conducted in the manner of direct examination and may proceed by leading questions only if the witness is a hostile witness, an adverse party, or a witness identified with an adverse party.

(f) Upon motion of any party, the ALJ shall order witnesses excluded so that they cannot hear the testimony of other witnesses. This rule does not authorize exclusion of—

(1) A party who is an individual;

(2) In the case of a party that is not an individual, an officer or employee of the party designated by the party's representative; or

(3) An individual whose presence is shown by a party to be essential to the presentation of its case, including an individual employed by the Government engaged in assisting the representative for the Government.

§ 355.34 Evidence.

(a) The ALJ shall determine the admissibility of evidence.

(b) Except as provided herein, the ALJ shall not be bound by the Federal Rules of Evidence. However, the ALJ may apply the Federal Rules of Evidence where appropriate, *e.g.,* to exclude unreliable evidence.

(c) The ALJ shall exclude irrelevant and immaterial evidence.

(d) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.

(e) Although relevant, evidence may be excluded if it is privileged under Federal law.

(f) Evidence concerning offers of compromise or settlement shall be inadmissible to the extent provided in Rule 408 of the Federal Rules of Evidence.

(g) The ALJ shall permit the parties to introduce rebuttal witnesses and evidence.

(h) All documents and other evidence offered or taken for the record shall be open to examination by all parties, unless otherwise ordered by the ALJ pursuant to § 355.24.

§ 355.35 The record.

(a) The hearing will be recorded and transcribed. Transcripts may be obtained following the hearing from the ALJ at a cost not to exceed the actual cost of duplication.

(b) The transcript of testimony, exhibits and other evidence admitted at the hearing, and all papers and requests filed in the proceeding constitute the record for the decision by the ALJ and the authority head.

(c) The record may be inspected and copied (upon payment of a reasonable fee) by anyone, unless otherwise ordered by the ALJ pursuant to § 355.24.

§ 355.36 Post-hearing briefs.

The ALJ may require the parties to file post-hearing briefs. In any event, any party may file a post-hearing brief. The ALJ shall fix the time for filing such briefs, not to exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record. Such briefs may be accompanied by proposed findings of fact and conclusions of law. The ALJ may permit the parties to file reply briefs.

§ 355.37 Initial decision.

(a) The ALJ shall issue an initial decision based only on the record, which

shall contain findings of fact, conclusions of law, and the amount of any penalties and assessments imposed.

(b) The findings of fact shall include a finding on each of the following issues:

(1) Whether the claims or statements identified in the complaint, or any portions thereof, violate § 355.3;

(2) If the person is liable for penalties or assessments, the appropriate amount of any such penalties or assessments considering any mitigating or aggravating factors that he or she finds in the case, such as those described in § 355.31.

(c) The ALJ shall promptly serve the initial decision on all parties within 90 days after the time for submission of post-hearing briefs and reply briefs (if permitted) has expired. The ALJ shall at the same time serve all defendants with a statement describing the right of any defendant determined to be liable for a civil penalty or assessment to file a motion for reconsideration with the ALJ or a notice of appeal with the authority head. If the ALJ fails to meet the deadline contained in this paragraph, he or she shall notify the parties of the reason for the delay and shall set a new deadline.

(d) Unless the initial decision of the ALJ is timely appealed to the authority head, or a motion for reconsideration of the initial decision is timely filed, the initial decision shall constitute the final decision of the authority head and shall be final and binding on the parties 30 days after it is issued by the ALJ.

§ 355.38 Reconsideration of initial decision.

(a) Except as provided in paragraph (d) of this section, any party may file a motion for reconsideration of the initial decision within 20 days of receipt of the initial decision. If service was made by mail, receipt will be presumed to be five days from the date of mailing in the absence of contrary proof.

(b) Every such motion must set forth the matters claimed to have been erroneously decided and the nature of the alleged errors. Such motion shall be accompanied by a supporting brief.

(c) Responses to such motions shall be allowed only upon request of the ALJ.

(d) No party may file a motion for reconsideration of an initial decision that has been revised in response to a previous motion for reconsideration.

(e) The ALJ may dispose of a motion for reconsideration by denying it or by issuing a revised initial decision.

(f) When a motion for reconsideration is made, the time periods for appeal to the authority head contained in this section, and for finality of the initial decision in § 355.36(d), shall begin on the date the ALJ issues the denial of the motion for reconsideration or a revised initial decision, as appropriate.

§ 355.39 Appeal to authority head.

(a) Any defendant who has filed a timely answer and who is determined in an initial decision to be liable for a civil penalty or assessment may appeal such decision to the authority head by filing a notice of appeal with the authority head in accordance with this section.

(b)(1) No notice of appeal may be filed until the time period for filing a motion for reconsideration under § 355.38 has expired.

(2) If a motion for reconsideration is timely filed, a notice of appeal must be filed within 30 days after the ALJ denies the motion or issues a revised initial decision, whichever applies.

(3) If no motion for reconsideration is timely filed, a notice of appeal must be filed within 30 days after the ALJ issues the initial decision.

(4) The authority head may extend the initial 30-day period for an additional 30 days if the defendant files with the authority head a request for an extension within the initial 30-day period and shows good cause.

(c) If the defendant files a timely notice of appeal with the authority head, the ALJ shall forward the record of the proceeding to the authority head.

(d) A notice of appeal shall be accompanied by a written brief specifying exceptions to the initial decision and reasons supporting the exceptions.

(e) The representative for the Government may file a brief in opposition

to exceptions within 30 days of receiving the notice of appeal and accompanying brief.

(f) There is no right to appear personally before the authority head.

(g) There is no right to appeal any interlocutory ruling by the ALJ.

(h) In reviewing the initial decision, the authority head shall not consider any objection that was not raised before the ALJ unless a demonstration is made of extraordinary circumstances causing the failure to raise the objection.

(i) If any party demonstrates to the satisfaction of the authority head that additional evidene not presented at such hearing is material and that there were reasonable grounds for the failure to present such evidence at such hearing, the authority head shall remand the matter to the ALJ for consideration of such additional evidence.

(j) The authority head may affirm, reduce, reverse, compromise, remand, or settle any penalty or assessment, determined by the ALJ in any initial decision.

(k) The authority head shall promptly serve each party to the appeal with a copy of the decision of the authority head. At the same time the authority head shall serve the defendant with a statement describing the defendant's right to seek judicial review.

(l) Unless a petition for review is filed as provided in 31 U.S.C. 3805 after a defendant has exhausted all administrative remedies under this part and within 60 days after the date on which the authority head serves the defendant with a copy of the authority head's decision, a determination that a defendant is liable under § 355.3 is final and is not subject to judicial review.

§ 355.40 Stays ordered by the Department of Justice.

If at any time the Attorney General or an Assistant Attorney General designated by the Attorney General transmits to the authority head a written finding that continuation of the administrative process described in this part with respect to a claim or statement may adversely affect any pending or potential criminal or civil action related to such claim or statement, the authority head shall stay the process immediately. The authority head may order the process resumed only upon receipt of the written authorization of the Attorney General.

§ 355.41 Stay pending appeal.

(a) An initial decision is stayed automatically pending disposition of a motion for reconsideration or of an appeal to the authority head.

(b) No administrative stay is available following a final decision of the authority head.

§ 355.42 Judicial review.

Section 3805 of title 31 U.S. Code authorizes judicial review by an appropriate U.S. District Court of a final decision of the authority head imposing penalties or assessments under this part and specifies the procedures for such review.

§ 355.43 Collection of civil penalties and assessments.

Sections 3806 and 3808(b) of title 31 U.S. Code, authorize actions for collection of civil penalties and assessments imposed under this part and specify the procedures for such actions.

§ 355.44 Right to administrative offset.

The amount of any penalty or assessment which has become final, or for which a judgment has been entered under § 355.42 or § 355.43, or any amount agreed upon in a compromise or settlement under § 355.46, may be collected by administrative offset under 31 U.S.C. 3716, except that an administrative offset may not be made under this subsection against a refund of an overpayment of Federal taxes, then or later owing by the United States to the defendant.

§ 355.45 Deposit in Treasury of United States.

All amounts collected pursuant to this part shall be deposited as miscellaneous receipts in the Treasury of the United States, except as provided in 31 U.S.C. 3806(g).

§ 355.46 Compromise or settlement.

(a) Parties may make offers of compromise or settlement at any time.

(b) The reviewing official has the exclusive authority to compromise or

settle a case under this part at any time after the date on which the reviewing official is permitted to issue a complaint and before the date on which the ALJ issues an initial decision.

(c) The authority head has exclusive authority to compromise or settle a case under this part at any time after the date on which the ALJ issues an initial decision, except during the pendency of any review under § 355.42 or during the pendency of any action to collect penalties and assessments under § 355.43.

(d) The Attorney General has exclusive authority to compromise or settle a case under this part during the pendency of any review under § 355.42 or of any action to recover penalties and assessments under 31 U.S.C. 3806.

(e) The investigating official may recommend settlement terms to the reviewing official, the authority head, or the Attorney General, as appropriate. The reviewing official may recommend settlement terms to the authority head, or the Attorney General, as appropriate.

(f) Any compromise or settlement must be in writing.

§ 355.47 Limitations.

(a) The notice of hearing with respect to a claim or statement must be served in the manner specified in § 355.8 within 6 years after the date on which such claim or statement is made.

(b) If the defendant fails to file a timely answer, service of a notice under § 355.10(b) shall be deemed a notice of hearing for purposes of this section.

(c) The statute of limitations may be extended by agreement of the parties.

PART 356—CIVIL MONETARY PENALTY INFLATION ADJUSTMENT

Sec.

356.1 Introduction.
356.2 Program Fraud Civil Remedies Act of 1986.
356.3 False claims.

AUTHORITY: 28 U.S.C. 2461; 31 U.S.C. 3729, 3809.

SOURCE: 62 FR 3791, Jan. 27, 1997, unless otherwise noted.

§ 356.1 Introduction.

(a) The Federal Civil Penalties Inflation Adjustment Act requires that civil monetary penalties be adjusted by the percentage by which the Consumer Price Index for the month of June of the calendar year preceding the adjustment exceeds the Consumer Price Index for the month of June of the calendar year in which the amount of such civil monetary penalty was last set or adjusted. That Act also mandates rounding of the adjustment, depending on the amount of the maximum penalty.

(b) The ratio of the Consumer Price Index for the month of June of the calendar year preceding this adjustment to the Consumer Price Index for the month of June of the calendar year in which the amount of civil monetary penalties provided for under the Program Fraud Civil Remedies Act (31 U.S.C. 3801–3812) and the false claims provisions at 31 U.S.C. 3729(a) was last set or adjusted, 1986, is 456.7/327.9, which produces the following increases in the penalties after applicable rounding:

(1) The maximum penalty under the Program Fraud Civil Remedies Act for a false claim or statement would be increased from $5,000 to $7,000.

(2) The maximum and minimum penalties under the false claims provisions at 31 U.S.C. 3729(a) would be increased from $10,000 to $14,000 and $5,000 to $7,000, respectively.

(c) Imposition of the increases are limited to actions occurring after the effective date of the increases.

(d) No increase may exceed ten percent of the penalty or range of penalties, as applicable.

§ 356.2 Program Fraud Civil Remedies Act of 1986.

In the case of penalties assessed under part 355 of this chapter, an additional penalty of $500 may be assessed for claims or statements made after October 23, 1996.

§ 356.3 False claims.

In the case of penalties assessed under 31 U.S.C. 3729 based on actions occurring after October 23, 1996, the minimum penalty is $5,500 and the maximum penalty is $11,000.

SUBCHAPTER F—INTERNAL ADMINISTRATION, POLICY AND PROCEDURES

PART 360 [RESERVED]

PART 361—RECOVERY OF DEBTS OWED TO THE UNITED STATES GOVERNMENT BY GOVERNMENT EMPLOYEES

Sec.

361.1 Purpose.
361.2 Scope.
361.3 Definitions.
361.4 Determination of indebtedness.
361.5 Notice requirements before offset.
361.6 Requests for waiver or hearing.
361.7 Written decision following a hearing.
361.8 Limitations on notice and hearing requirements.
361.9 Exception to requirement that a hearing be offered.
361.10 Written agreement to repay debt as alternative to salary offset.
361.11 Procedures for salary offset: When deductions may begin.
361.12 Procedures for salary offset: Types of collection.
361.13 Procedures for salary offset: Methods of collection.
361.14 Procedures for salary offset: Imposition of interest, penalties and administrative costs.
361.15 Non-waiver of rights.
361.16 Refunds.
361.17 Coordination with other government agencies.

AUTHORITY: 5 U.S.C. 5514(b)(1).

SOURCE: 53 FR 45262, Nov. 9, 1988, unless otherwise noted.

§ 361.1 Purpose.

These regulations, which implement 5 U.S.C. 5514, provide the standards and procedures which the Board will utilize to collect debts owed to the United States from the current pay accounts of its employees, including the current pay accounts of employees who owe debts to agencies other than the Board.

§ 361.2 Scope.

(a) *Coverage.* This part applies to agencies and employees as defined by § 361.3 of this part.

(b) *Applicability.* This part and 5 U.S.C. 5514 apply in recovering certain debts by administrative offset, except where the employee consents to the recovery, from the current pay account of an employee. Because it is an administrative offset, debt collection procedures for salary offset which are not specified in 5 U.S.C. 5514 and these regulations shall be consistent with the provisions of the Federal Claims Collection Standards (FCCS).

(1) *Excluded debts or claims.* The procedures contained in this part do not apply to debts or claims arising under the Internal Revenue Code of 1954 as amended (26 U.S.C. 1, *et seq.*), the Social Security Act (42 U.S.C. 301, *et seq.*), or the tariff laws of the United States; or to any case where collection of a debt by salary offset is explicitly provided for or prohibited by another statute (*e.g.*, travel advances in 5 U.S.C. 5705 and employee training expenses in 5 U.S.C. 4108).

(2) *Waiver requests and claims to the U.S. General Accounting Office.* This part does not preclude an employee from requesting waiver of recovery of an overpayment under 5 U.S.C. 5584 or any other similar provision of law, or from questioning the amount of validity of a debt by submitting a subsequent claim to the U.S. General Accounting Office.

(3) *Compromise, suspension, or termination under the Federal Claims Collection Standards (4 CFR 101.1, et seq.).* Nothing in this part precludes the compromise, suspension or termination of collection actions where appropriate under the standards implementing 31 U.S.C. 3711, *et seq.* (4 CFR 101.1, *et seq.*).

§ 361.3 Definitions.

For purposes of this part, terms are defined as follows:

Agency means—

(a) An executive agency as defined by section 105 of title 5, United States Code; including the U.S. Postal Service and the U.S. Postal Rate Commission;

(b) A military department as defined in section 102 of title 5, United States Code;

(c) An agency or court in the judicial branch, including a court as defined in section 610 of title 28, United States

Court for the Northern Mariana Islands, and the Judicial Panel on Multidistrict Litigation;

(d) An agency of the legislative branch, including the U.S. Senate and the U.S. House of Representatives; and

(e) Other independent establishments that are entities of the Federal government.

Creditor agency means the agency to which the debt is owed.

Debt means an amount owed to the United States from sources which include loans insured or guaranteed by the United States and all other amounts due the United States from fees, leases, rents, royalties, services, sales of real or personal property, overpayments, fines, penalties, damages, interest, forfeitures (except those arising under the Uniform Code of Military Justice), and all other similar sources.

Delinquent debt means a debt which has not been paid by the date specified in the creditor agency's initial written notification, unless satisfactory arrangements for payment have been made by that date, or where, at any time thereafter, the employee fails to satisfy his or her obligations under a payment agreement with the creditor agency.

Disposable pay means that part of current basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay, remaining after the deduction of any amount required by law to be withheld. Agencies must exclude deductions described in 5 CFR 581.104 (b) through (f) to determine disposable pay subject to salary offset.

Employee means a current employee of a Federal agency, including a current member of the Armed Forces or a Reserve of the Armed Forces (Reserves).

FCCS means the Federal Claims Collection Standards jointly published by the Department of Justice and the U.S. General Accounting Office at 4 CFR 101.1, *et seq*.

Paying agency means the Federal agency or branch of the Armed Forces or Reserves employing the individual and disbursing his or her current pay account.

Salary offset means an administrative offset to collect a debt under 5 U.S.C. 5514 by deduction(s) at one or more officially established pay intervals from the current pay account of an employee without his or her consent.

Waiver means the cancellation, remission, forgiveness, or non-recovery of a debt allegedly owed by an employee to an agency as permitted or required by 5 U.S.C. 5584, 5 U.S.C. 8346(b), 10 U.S.C. 2774, 32 U.S.C. 716, or any other similar law.

§ 361.4 Determination of indebtedness.

In determining that an employee is indebted, the Board will review the debt to make sure it is valid and past due.

§ 361.5 Notice requirements before offset.

The Board shall provide an employee written Notice of Intent to Offset Salary (Notice of Intent). The employee will be provided the notice at least thirty calendar days before the intended deduction is to begin. In addition, the notice must provide the following:

(a) That the Board has reviewed the records relating to the claim and has determined that a debt is owed, and the origin, nature, and amount of that debt;

(b) The Board's intention to collect the debt by means of deduction from the employee's current disposable pay account;

(c) The amount, frequency, approximate beginning date, and duration of the intended deductions;

(d) An explanation of the Board's requirements concerning interest, penalties, and administrative costs, and notification that such assessment must be made unless such payments are excused in accordance with the FCCS;

(e) Advice as to the employee's or his or her representative's right to inspect and copy or to be provided copies of government records relating to the debt;

(f) If not previously provided, notification of the opportunity (under terms agreeable to the Board) to establish a schedule for the voluntary repayment of the debt or to enter into a written agreement to establish a schedule for

repayment of the debt in lieu of offset. The agreement must be in writing, signed by both the employee and the Board, and documented in the Board's files (4 CFR 102.2(e));

(g) Advice that the Board will accept a repayment agreement which is reasonable in view of the financial condition of the employee at that time;

(h) If there is a statutory provision for waiver, cancellation, remission or forgiveness of the debt to be collected, advice that waiver may be requested within the period and by the procedure specified and explaining the conditions under which waiver, cancellation, remission or forgiveness is granted;

(i) Advice as to the employee's right to a hearing conducted by an official arranged by the Board (an administrative law judge, or alternatively, a hearing official not under the control of the head of the agency) on the Board's determination of the debt, the amount of the debt, and the percentage of disposable pay to be deducted each pay period if a petition is filed as prescribed by the Board;

(j) Advice that the timely filing of a petition for hearing or a request for waiver (if the waiver statute or regulations are not ''permissive'' in nature) will stay the commencement of collection proceedings;

(k) Advice that a final decision on the hearing (if one is requested) will be issued at the earliest practical date, but not later than sixty days after the filing of the petition requesting the hearing unless the employee requests and the hearing official grants a delay in the proceedings;

(l) Advice as to the method and time period for requesting a hearing as provided for in § 361.5 and for requesting waiver, if it is available;

(m) Advice that any knowingly false or frivolous statements, representations, or evidence may subject the employee to:

(1) Disciplinary procedures appropriate under chapter 75 of title 5, United States Code, part 752 of title 5, Code of Federal Regulations, or any other applicable statutes or regulations;

(2) Penalties under the False Claims Act, sections 3729–3731 of title 31, United States Code, or any other applicable statutory authority; or

(3) Criminal penalties under sections 286, 287, 1001, and 1002 of title 18, United States Code, or any other applicable statutory authority;

(n) Advice as to other rights and remedies available to the employee under statutes or regulations governing the program for which the collection is being made; and

(o) Advice that unless there are applicable contractual or statutory provisions to the contrary, amounts paid on or deducted for the debt which are later waived or found not owed to the United States will be promptly refunded to the employee. Such refunds will not bear interest unless required or permitted by law.

§ 361.6 Requests for waiver or hearing.

(a) A request for waiver or for a hearing must be made in writing and received by the Chief Financial Officer no later than thirty calendar days after the notice is sent to the employee. This time limit may, at the discretion of the Chief Financial Officer, be extended if the employee can show that the delay was caused by circumstances which were beyond the employee's control or because of the employee's failure to receive notice of the time limit. Any right to waiver or to a hearing is forfeited unless the time limits set forth in this paragraph are complied with.

(b) The employee's request for a hearing must be signed by the employee and fully identify and explain with reasonable specificity all the facts, evidence and witnesses, if any, which the employee believes support his or her position.

(c) A request for a hearing under this paragraph is not a request for waiver. A request for waiver must state the basis for the request for waiver and whether a hearing is requested. If no request for a hearing is contained in the waiver request, no hearing will be provided.

(d) A hearing, if requested, will be an informal proceeding conducted by an administrative law judge or hearing official not under the control of the Board. The employee, or his/her representative, and the Board will be

given full opportunity to present evidence, witnesses and argument.

§ 361.7 Written decision following a hearing.

Within thirty days after the hearing, the administrative law judge or hearing official shall issue a written decision stating the facts evidencing the nature and origin of the alleged debt; the amount and validity of the alleged debt; and the judge or hearing official's analysis, findings and conclusions with respect to the employee's position on liability for the debt and with respect to his or her eligibility for waiver. The decision of the administrative law judge or hearing official shall be the final agency decision.

§ 361.8 Limitations on notice and hearing requirements.

(a) The procedural requirements of this part are not applicable to collections which result from:

(1) An employee's election of coverage or of a change in coverage under a Federal benefits program which requires periodic deductions from pay and which cannot be placed into effect immediately because of normal processing delays; and

(2) Ministerial adjustments in pay rates or allowances which cannot be placed into effect immediately because of normal processing delays.

(b) *Limited procedures.* If the period of the normal processing delay for which the retroactive deduction must be recovered does not exceed four pay periods, the procedures provided in §§ 361.4 and 361.5 of this part shall not apply, but the Board shall in advance of the collection issue a general notice that:

(1) Because of the employee's election, future salary will be reduced to cover the period between the effective date of the election and the first regular withholding, and the employee may dispute the amount of the retroactive collection by notifying a specified office or official; or

(2) Due to a normal ministerial adjustment in pay or allowances which could not be placed into effect immediately, future salary will be reduced to cover any excess pay or allowances received by the employee, the employee may dispute the amount of the retroactive collection by notifying a specified office or official.

(c) *Limitation on exceptions.* The exceptions described in paragraphs (a) and (b) of this section shall not include a recovery required to be made for any reason other than normal processing delays in putting the change into effect, even if the period of time for which the amounts must be retroactively withheld is less than four pay periods. Further, if normal processing delays exceed four pay periods, then the full procedures prescribed under §§ 361.4 and 361.5 of this part shall be extended to the employee.

§ 361.9 Exception to requirement that a hearing be offered.

When an employee is overpaid due to the hours worked reported on the payroll exceeding the actual hours worked, no pre-offset hearing must be granted since in such cases there is no question regarding credibility and veracity. In these cases the Board will make its determination under this part based upon review of the written record.

§ 361.10 Written agreement to repay debt as alternative to salary offset.

(a) *Notification by employee.* The employee may propose, in response to a Notice of Intent, a written agreement to repay the debt as an alternative to salary offset. Any employee who wishes to do this must submit a proposed written agreement to repay the debt which is received by the Board within thirty calendar days of the date of the Notice of Intent.

(b) *Board's response.* In response to timely notice by the debtor as described in paragraph (a) of this section, the Board will notify the employee whether the employee's proposed written agreement for repayment is acceptable. It is within the Board's discretion to accept a repayment agreement instead of proceeding by offset. In making this determination, the Board will balance the agency's interest in collecting the debt against hardship to the employee. If the debt is delinquent and the employee has not disputed its existence or amount, the Board will accept a repayment agreement instead of offset only if the employee is able to establish that offset would result in

undue financial hardship or would be against equity and good conscience.

§ 361.11 Procedures for salary offset: When deductions may begin.

(a) Deductions to liquidate an employee's debt will be by the method and in the amount stated in the Notice of Intent to collect from the employee's current pay.

(b) If the employee filed a petition for hearing with the Board before the expiration of the period provided for in § 361.5, then deductions will begin after the hearing officer has provided the employee with a hearing and the hearing officer's final written decision is in favor of the Board.

(c) If an employee retires, resigns or his or her period of employment ends before collection of a debt is completed, offset shall be made from subsequent payments of any nature (*e.g.*, final salary payment, lump sum leave, etc.) due the employee from the Board to the extent necessary to liquidate the debt. If the debt cannot be liquidated by offset from any final payment due the employee from the Board, the Board shall liquidate the debt by administrative offset, pursuant to 31 U.S.C. 3716, from later payments of any kind which are due the employee from the United States.

§ 361.12 Procedures for salary offset: Types of collection.

A debt will be collected in a lump sum or in installments. Collection will be effected in one lump sum collection unless the employee is financially unable to pay in one lump sum, or if the amount of the debt exceeds 15 percent of disposable pay. In these cases, deduction will be by installments.

§ 361.13 Procedures for salary offset: Methods of collection.

(a) *General.* A debt will be collected by deductions at officially-established pay intervals from an employee's current pay account, unless the employee and the Board agree to alternative arrangements for repayment. The alternative arrangement must be in writing, signed by both the employee and the Board.

(b) *Installment deductions.* Installment deductions will be made over a period not greater than the anticipated period of employment. The size and frequency of installment deductions will bear a reasonable relation to the size of the debt and the employee's ability to pay. However, the amount deducted for any period will not exceed 15 percent of the disposable pay from which the deduction is made, unless the employee has agreed in writing to the deduction of a greater amount. If possible, the installment payment will be sufficient in size and frequency to liquidate the debt in three years. Installment payments of less than $25 per pay period or $50 a month will be accepted only in the most unusual circumstances.

(c) *Sources of deductions.* The Board will make deductions only from basic pay, special pay, incentive pay, retired pay, retainer pay, or in the case of an employee not entitled to basic pay, other authorized pay.

§ 361.14 Procedures for salary offset: Imposition of interest, penalties and administrative costs.

Interest will be charged in accordance with 4 CFR 102.13.

§ 361.15 Non-waiver of rights.

So long as there are no statutory or contractual provisions to the contrary, no employee involuntary payment (of all or a portion of a debt) collected under these regulations will be interpreted as a waiver of any rights that the employee may have under 5 U.S.C. 5514.

§ 361.16 Refunds.

The Board will refund promptly to the appropriate individual amounts offset under these regulations when:

(a) A debt is waived or otherwise found not owing the United States (unless expressly prohibited by statute or regulation); or

(b) The Board is directed by an administrative or judicial order to refund amounts deducted from the employee's current pay.

§ 361.17 Coordination with other government agencies.

(a) *Board is paying agency.* (1) If the Board receives a claim which meets the requirements of 5 CFR 550.1108 from another agency, deductions shall begin

prospectively at the next officially established pay interval. The employee will receive written notice that the Board has received a certified debt claim from a creditor agency. The notice will contain the amount of the debt and the date deductions from salary will commence and the amount of such deductions.

(2) If the Board receives a claim which does not meet the requirements of 5 CFR 550.1108, then the Board will return the claim to the creditor agency and inform the creditor agency that before any action is taken to collect the debt from the employee's current pay account, the procedures under 5 U.S.C. 5514 and 5 CFR part 550 must be followed and a claim which meets the requirements of 5 CFR 550.1108 must be received.

(b) *Board is creditor agency*. When the Board is owed a debt by an employee of another agency, the other agency shall not initiate the requested offset until the Board provides the agency with a written certification that the procedures under this part have been followed and the Board has provided the other agency with a claim which meets the requirement of 5 CFR 550.1108.

PART 362—EMPLOYEES' PERSONAL PROPERTY CLAIMS

Sec.

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362.4 Delegation of authority.
362.5 Time limits for filing a claim.
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AUTHORITY: Sec. 3(a), Pub. L. 88–558, 78 Stat. 767 (31 U.S.C. 241(b)(1)), unless otherwise noted.

SOURCE: 45 FR 57709, Aug. 29, 1980, unless otherwise noted.

§ 362.1 Purposes.

(a) This part prescribes regulations under the Military Personnel and Civilian Employees' Claims Act of 1964, as amended, for the settlement of a claim against the United States made by an officer or employee of the Railroad Retirement Board for damage to, or loss of, personal property incident to his service. In accordance with that Act, the possession of such property must be reasonable, useful, or proper under the circumstances.

(b) The Railroad Retirement Board is not an insurer of its officers' or employees' personal property and does not underwrite the damage or loss of such property that may be sustained by an officer or employee. Officers and employees of the Board are encouraged to carry private insurance to the maximum extent practicable to avoid large losses or losses which may not be recoverable from the Board. The procedures set forth in this section are designed to enable the claimant to obtain the maximum amount of otherwise unreimbursed or uninsured compensation for his loss or damage. Failure of the claimant to comply with these procedures may reduce or preclude payment of his claim under this part.

§ 362.2 Definitions.

As used in this part:

(a) *Act* means the Military Personnel and Civilian Employees' Claims Act of 1964, as amended (31 U.S.C. 240–243).

(b) *Article of extraordinary value* means an article which was purchased or which the employee values at a monetary amount which is in excess of the usual, regular or customary amount paid for an article which is capable of accomplishing the same purposes.

(c) *Benefit of the Board* means that the operations and service of the Board were assisted, facilitated or improved.

(d) *Board* means the Railroad Retirement Board.

(e) *Employee* means an officer or employee of the Board.

(f) *Settle* means consider, ascertain, adjust, determine and dispose of any claim, whether by full or partial allowance or by disallowance.

§ 362.3 Who may file a claim.

A claim may be filed by an employee, by his spouse in his name as authorized agent, or by any other authorized agent or legal representative of the employee. If the employee is dead, his (a) spouse, (b) child, (c) father or mother, or both, or (d) brother or sister, or both, may file the claim and be entitled to payment in that order of priority.

§ 362.4 Delegation of authority.

The Deputy General Counsel of the Board is authorized to settle any claim filed under this part.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.5 Time limits for filing a claim.

A claim under this part may be considered only if:

(a) The damage or loss occurred after August 31, 1964; and

(b) The claim is filed in writing within two years after the damage, loss or theft occurred or became known to the employee.

§ 362.6 Procedure for filing a claim.

(a) Railroad Retirement Board Form G–108, Employee Claim for Loss or Damage to Personal Property, is the prescribed form for filing claims pursuant to the regulations in this part and must be completed by the employee, the person acting on his behalf, or his survivor and forwarded directly to the General Counsel of the Board for processing. Railroad Retirement Board Form G–108 may be obtained from the Board's Bureau of Law.

(b) In addition to the information required to complete the form described § 362.6(a), the following information or data must be submitted with each claim:

(1) With respect to claims involving property which is stolen or lost, the purchase receipt, or if not available, statements from the employee estimating the value and what security measures or precautions were taken to protect the property;

(2) With respect to claims involving property which is damaged, an itemized repair estimate from an appropriate commercial source, or, if beyond repair, a statement from an appropriate commercial source or, if such a statement is not available, from the employee, indicating that the damaged property is beyond repair;

(3) With respect to claims involving property stated to be beyond repair in accordance with paragraph (b)(2) of this section, a statement from the employee estimating the value and the purchase receipt, if available;

(4) With respect to claims considered under § 362.10(b)(3), a statement by the employee's supervisor verifying that the supervisor required the employee to provide, or that the supervisor consented to having the employee provide, such property and that the provision of such personal property was in the interest of the Board;

(5) With respect to a claim filed by an agent or survivor of an employee, a power of attorney or other satisfactory evidence of authority to file the claim.

§ 362.7 Factors to be considered in settling a claim.

Claims are payable only for such types, quantities or amounts of tangible personal property as the Deputy General Counsel of the Board shall determine to be reasonable, useful, or proper under the circumstances existing at the time and place of the loss, theft or damage of the property. In determining what is reasonable, useful or proper the Deputy General Counsel will consider the type and quantity of property involved, the circumstances attending acquisition and use of the property, and whether possession or use by the employee at the time of loss, theft or damage was incident to the employee's service. What is reasonable, useful or proper is a question of fact to be determined by the Deputy General Counsel.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.8 Investigation of a claim.

The Deputy General Counsel or his designee may investigate the circumstances surrounding the theft, loss or damage of an employee's property.

In order to complete such investigation, the Deputy General Counsel or his designee may request the submission of information in addition to that described in § 362.7 of this part.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.9 Fraudulent claims.

Claims are not payable for items fraudulently claimed. When investigation discloses that an employee, an agent of the employee, or a survivor of the employee has intentionally misrepresented an item claimed, as to cost, condition, cost of repair or other significant information, the claim as to that item will be disallowed in its entirety even though some actual loss or damage may have been sustained. However, if the remainder of the claim is proper it will be paid as to other items. This section does not preclude appropriate prosecution and disciplinary action if warranted.

§ 362.10 Principal types of claims allowable.

(a) In general, a claim may be allowed only for tangible personal property of a type and quantity that was, from the Board's perspective, reasonable, useful, or proper for the employee to possess under the circumstances at the time of the loss or damage. Any questions in this regard are to be resolved by the Deputy General Counsel.

(b) Claims that will ordinarily be allowed include, but are not limited to, cases in which the loss or damage occurred:

(1) In a common or natural disaster;

(2) When the property was subjected to extraordinary risks in the performance of duty or efforts to save human life or property of the United States Government;

(3) When the property was used for the benefit of the Board at the direction, or with the consent, of a supervisor.

(45 U.S.C. 231f(b)(5))

[45 FR 57709, Aug. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 362.11 Principal types of claims not allowable.

(a) Claims will be disallowed when:

(1) The personal property was lost, stolen or damaged prior to August 31, 1964;

(2) The loss or damage totals less than $5 or, to the extent of the excess, more than the maximum amount provided in section 241(b)(1) of title 31 of the U.S. Code;

(3) The loss or damage was caused, at least in part, by the negligence of the employee or his agent;

(4) The personal property was acquired, possessed or transported in violation of law or regulation;

(5) The personal property was brought into Board offices for temporary storage in anticipation of delivery to another person or removal to another location;

(6) The personal property lost or damaged was food-stuffs or furniture;

(b) Claims which will ordinarily not be allowed include, but are not limited to, claims for:

(1) Money or currency, except when lost in a common or natural disaster;

(2) Articles of extraordinary value;

(3) Articles being worn (unless allowable under § 362.10);

(4) Intangible property, such as bank books, checks, notes, stock certificates, money orders or travelers' checks;

(5) Property owned by the United States, unless the employee is financially responsible for it to another U.S. Government agency;

(6) Losses of insurers or subrogees and those losses recoverable from an insurer or carrier;

(7) Losses or damages sustained in quarters not assigned or otherwise provided in kind by the Board;

(8) Losses recoverable or recovered pursuant to contract;

(9) Loss or damage to any vehicle used for transportation or in transportation (unless allowable under § 362.10).

§ 362.12 Computation of amount of reimbursement.

(a) The amount awarded with regard to any item of personal property will not exceed its depreciated replacement cost at the time of loss. Unless proven to be otherwise, replacement cost will

be based on the price paid in cash for the property or, if not acquired by purchase or exchange, the value at the time of acquisition. The amount normally payable on property damaged beyond economical repair is found by determining its depreciated value immediately before it was damaged or lost, less any salvage value. If the cost of repair is less than the depreciated value of the property, then it is economically repairable, and the cost of repair is the amount payable.

(b) Depreciation in value of an item of personal property is determined by considering the type of article involved, its cost, condition when lost or damaged beyond economical repair, and the time elapsed between the date of acquisition and the date of accrual of the claim.

(c) Allowance for articles acquired by barter will not exceed the cost of the articles tendered in barter.

§ 362.13 Property recovered after payment of claim.

When previously lost or stolen property is recovered by the employee after allowance of a claim by the Board, the employee shall return the amount of reimbursement.

§ 362.14 Finality of settlement.

Notwithstanding any other provision of law, settlement of a claim under the Act and this part is final and conclusive.

§ 362.15 Agent's or attorney's fee.

Under the terms of the Act, no more than 10 percent of the amount paid in settlement of a claim submitted and settled under this part may be paid or delivered to or received by any agent or attorney on account of services rendered in connection with that claim, any contract to the contrary notwithstanding.

PART 363—GARNISHMENT OF REMUNERATION OF BOARD PERSONNEL

Sec.

363.1 Authorization for garnishment of remuneration for employment paid by the Board.
363.2 Definitions.
363.3 Procedure.
363.4 Exemptions.
363.5 Miscellaneous.

AUTHORITY: 15 U.S.C. 1673(b)(2); 42 U.S.C. 659, 661, and 662; and 45 U.S.C. 231f(b)(5) and 362(1).

SOURCE: 45 FR 28315, Apr. 29, 1980, unless otherwise noted.

§ 363.1 Authorization for garnishment of remuneration for employment paid by the Board.

(a) Remuneration for employment paid or payable by the Board is subject, in like manner and to the same extent as if the Board were a private person, to legal process brought for the enforcement of legal obligations to provide child support or to make alimony payments.

(b) Remuneration for employment includes compensation paid or payable for personal services, whether such compensation is denominated as wages, salary, commission, bonus, pay, or otherwise, and includes, but is not limited to, severance pay, sick pay, and incentive pay, but does not include awards for making suggestions.

(c) Remuneration for employment does not include:

(1) Amounts required by law to be deducted, including but not limited to Federal employment taxes and civil service retirement contributions;

(2) Amounts which are deducted as health insurance premiums;

(3) Amounts which are deducted as premiums for regular life insurance coverage; and

(4) Amounts which are properly withheld for Federal, state, or local income tax purposes, if the withholding of such amounts is authorized or required by law and if amounts withheld are not greater than would be the case if the individual concerned claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1954 may be permitted only when such individual presents evidence of a tax obligation which supports the additional withholding).

§ 363.2 Definitions.

(a) *Child support* means periodic payments of funds for the support and maintenance of a child or children;

such term also includes attorney's fees, interest, and court costs, when and to the same extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accordance with applicable state law by a court of competent jurisdiction.

(b) *Alimony* means periodic payments of funds for the support and maintenance of a spouse or former spouse and, subject to and in accord with state law, includes but is not limited to, separate maintenance, alimony pendente lite, maintenance, and spousal support; such term also includes attorney's fees, interest, and court costs, when and to the extent that they are expressly made recoverable pursuant to a decree, order, or judgment issued in accord with applicable state law by a court of competent jurisdiction. Alimony does not include any payment or transfer of property or of its value in compliance with any community property settlement, equitable distribution of property, or other division of property, nor does it include any payment to an estate.

(c) *Legal process* means any court order, summons, or other similar process, including administrative orders, in the nature of garnishment, which is directed to and the purpose of which is to compel the Board to make a payment from moneys which are otherwise payable to an individual, to another party in order to satisfy a legal obligation of such individual to provide child support or make alimony payments. Legal process additionally includes assignments in lieu of garnishment, but only where grounds for the issuance of legal process in the nature of garnishment exist. Such assignments are revocable.

§ 363.3 Procedure.

(a) Service of legal process brought for the enforcement of a Board employee's obligation to provide child support or make alimony payments shall be accomplished by certified or registered mail, return receipt requested, directed to the Deputy General Counsel of the Board, 844 Rush Street, Chicago, Illinois 60611, or by personal service upon the Deputy General Counsel.

(b) Where the Deputy General Counsel is effectively served with legal process relating to a Board employee's legal obligation to provide child support or to make alimony payments, he shall, as soon as possible and not later than 15 days after the date of effective service of such process, send written notice that such process has been so served, together with a copy thereof, to the individual whose moneys are affected thereby; and, if response to such process is required, shall respond within 30 days, or within such longer period as may be prescribed by state law, after the date effective service is made. These requirements do not apply in the case of an assignment in lieu of garnishment.

[45 FR 28315, Apr. 29, 1980, as amended at 48 FR 51448, Nov. 9, 1983]

§ 363.4 Exemptions.

(a) The portion of any payment due to a Board employee which is subject to legal process to enforce any order for the support of any person shall not exceed 65 percent. Where the individual is supporting a spouse or dependent child, other than a spouse or child with respect to whose support that legal process is issued, the portion subject to legal process is reduced by 10 percent. Where the alimony or support arrearage is less than 12 weeks old, the portion subject to legal process is reduced by 5 percent. If a lower limitation is provided by applicable state or local law, then that lower limitation shall be applied.

(b) In the absence of some evidence to the contrary, it will be assumed that the defendant is not supporting a spouse or dependent child other than a spouse or child with respect to whose support the legal process is issued.

§ 363.5 Miscellaneous.

(a) The Board may not be required to vary its normal disbursement cycles in order to comply with legal process.

(b) Except as provided in these regulations, the Board may not be required, in connection with proceedings under this part, to forward documents which have been sent to the Board, to an employee of the Board.

(c) Neither the Board nor any of its employees shall be liable with respect to any payment made to any individual from moneys due from or payable by the Board pursuant to legal process

regular on its face, if such payment is made in accordance with this part.

(d) No employee of the Board whose duties include responding to legal process pursuant to requirements contained in this part shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by such employee in connection with the performance of the employee's duties in responding to any such process.

(e) For purposes of a proceeding under this part the Board will apply the law of the state in which the legal process is issued unless it comes to the attention of the Board that the state of issuance has no contact with the plaintiff or defendant in the action; in which case, the Board may, in its sole discretion, apply the law of any state with significant interest in the matter.

PART 364—USE OF PENALTY MAIL TO ASSIST IN THE LOCATION AND RECOVERY OF MISSING CHILDREN

Sec.

364.1 Purpose.
364.2 Definitions.
364.3 Publication of missing children information in the Railroad Retirement Board's in-house publications.
364.4 Placement of missing children posters in Board field offices.
364.5 Further study of the use of penalty mail in the location and recovery of missing children.

AUTHORITY: 39 U.S.C. 3220(a)(2).

SOURCE: 52 FR 527 Jan. 7, 1987, unless otherwise noted.

§ 364.1 Purpose.

These regulations, which implement 39 U.S.C. 3220, provide the standards and guidelines for the use of Board penalty mail in the location and recovery of missing children.

§ 364.2 Definitions.

For purposes of this part, terms are defined as follows:

All-A-Board is the Board's in-house newspaper that is published on an irregular basis about six times a year.

Field office is a Board district office. These offices are located throughout the United States.

Penalty mail means the official mail of the Board that is used to carry out the Board's duties.

Shelf life means the amount of time the Board has to remove from circulation outdated missing children information. This is a three month period, commencing with the date notice is received by the National Center for Missing and Exploited Children that such information is no longer accurate.

§ 364.3 Publication of missing children information in the Railroad Retirement Board's in-house publications.

(a) *All-A-Board.* Information about missing children will appear in the All-A-Board. This publication will obtain the necessary information from the National Center for Missing and Exploited Children. The editorial staff of the All-A-Board shall determine the number of children described in each issue and where this information will appear in the publication.

(b) *Other in-house publications.* The Board may publish missing children information in other in-house publications as it deems appropriate. This determination will be made in accordance with the guidelines that appear in § 364.5.

§ 364.4 Placement of missing children posters in Board field offices.

(a) *Poster content.* The National Center for Missing and Exploited Children shall select the missing child and the pertinent information about that child, which may include a photograph of the child, that will appear on the poster. The Board will develop a standard format for these posters.

(b) *Transmission of posters to field offices.* The Board shall send the posters to its field offices in penalty mail. Those posters will be included in penalty mailings that are made in the normal course of the Board's operations.

(c) *Field office use of posters.* (1) Upon receipt of the poster, the field office will place it in the waiting room, if possible. Otherwise, the field office should put the poster in a place where it will be viewed by the public.

(2) The field office must remove and destroy the posters by the end of their shelf life. The field office also may remove posters that they believe have ceased to be of assistance in locating and recovering missing children.

§ 364.5 Further study of the use of penalty mail in the location and recovery of missing children.

(a) *Criteria.* The Board shall continue to study different alternatives for using penalty mail to assist in the location and recovery of missing children. In order to implement a proposal, it must:

(1) Be cost effective; and

(2) Fulfill the goal of aiding in the location and recovery of missing children.

(b) *Requirements.* In any program, the National Center for Missing and Exploited Children shall select the missing children and the information about these children, which may include a photograph, that will be used by the Board. Proposals must provide for the removal of this material before the end of its shelf life.

PART 365—ENFORCEMENT OF NONDISCRIMINATION ON THE BASIS OF HANDICAP IN PROGRAMS OR ACTIVITIES CONDUCTED BY THE RAILROAD RETIREMENT BOARD

Sec.

365.101 Purpose.
365.102 Application.
365.103 Definitions.
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365.160 Communications.
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365.170 Compliance procedures.
365.171–365.999 [Reserved]

AUTHORITY: 29 U.S.C. 794.

SOURCE: 53 FR 43434, Oct. 27, 1988, unless otherwise noted.

§ 365.101 Purpose.

The purpose of this part is to effectuate section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which amended section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of handicap in programs or activities conducted by Executive agencies or the United States Postal Service.

§ 365.102 Application.

This regulation (§§ 365.101 through 365.170) applies to all programs or activities conducted by the agency, except for programs or activities conducted outside the United States that do not involve individuals with handicaps in the United States.

§ 365.103 Definitions.

For purposes of this part, the term—

Agency means Railroad Retirement Board.

Assistant Attorney General means the Assistant Attorney General, Civil Rights Division, United States Department of Justice.

Auxiliary aids means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in, and enjoy the benefits of, programs or activities conducted by the agency. For example, auxiliary aids useful for persons with impaired vision include readers, brailled materials, audio recordings, and other similar services and devices. Auxiliary aids useful for persons with impaired hearing include telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf person (TDD's), interpreters, notetakers, written materials, and other similar services and devices.

Board means the three-member board, appointed pursuant to 45 U.S.C. 231f, which heads the agency.

Chief Executive Officer means the Chief Executive Officer of the Railroad Retirement Board. This individual is the chief operating officer of the agency.

Complete complaint means a written statement that contains the complainant's name and address and describes the agency's actions in sufficient detail to inform the agency of the nature and date of the alleged violation of section 504. It shall be signed by the complainant or by someone authorized to do so on his or her behalf. Complaints filed on behalf of classes or third parties shall describe or identify (by name, if possible) the alleged victims of discrimination.

Facility means all or any portion of buildings, structures, equipment, roads, walks, parking lots, rolling stock or other conveyances, or other real or personal property.

Individual with handicaps means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. As used in this definition, the phrase:

(1) *Physical or mental impairment* includes—

(i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs: cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or

(ii) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term ''physical or mental impairment'' includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, and drug addiction and alcoholism.

(2) *Major life activities* includes functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

(3) *Has a record of such an impairment* means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

(4) *Is regarded as having an impairment* means—

(i) Has a physical or mental impairment that does not substantially limit major life activities but is treated by the agency as constituting such a limitation;

(ii) Has a physical or mental impairment that substantially limits major life activities only as a result of the attitudes of others toward such impairment; or

(iii) Has none of the impairments defined in paragraph (1) of this definition but is treated by the agency as having such an impairment.

Qualified individual with handicaps means—

(1) An individual with handicaps who meets the essential eligibility requirements for participation in, or receipt of benefits from, a program or activity.

(2) *Qualified handicapped person* as that term is defined for purposes of employment in 29 CFR 1613.702(f), which is made applicable to this part by § 365.140.

Section 504 means section 504 of the Rehabilitation Act of 1973 (Pub. L. 93–112, 87 Stat. 394 (29 U.S.C. 794)), as amended by the Rehabilitation Act Amendments of 1974 (Pub. L. 93–516, 88 Stat. 1617); the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 (Pub. L. 95–602, 92 Stat. 2955); the Rehabilitation Act Amendments of 1986, (Pub. L. 99–506, 100 Stat. 1810), and the Civil Rights Restoration Act of 1987 (Pub. L. 100–259, 102 Stat. 28 (1988)). As used in this part, section 504 applies only to programs or activities conducted by Executive agencies and not to federally assisted programs.

§§ 365.104–365.109 [Reserved]

§ 365.110 Self-evaluation.

(a) The agency shall, by December 27, 1989, evaluate its current policies and practices, and the effects thereof, that do not or may not meet the requirements of this part, and, to the extent modification of any such policies and practices is required, the agency shall proceed to make the necessary modifications.

(b) The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the self-evaluation process by submitting comments (both oral and written).

(c) The agency shall, until at least three years following the completion of the self-evaluation, maintain on file and make available for public inspection:

(1) A description of areas examined and any problems identified, and

(2) A description of any modifications made.

§ 365.111 Notice.

The agency shall make available to employees, applicants, participants, beneficiaries, and other interested persons such information regarding the provisions of this part and its applicability to the programs or activities conducted by the agency, and make such information available to them in such manner as the agency head finds necessary to apprise such persons of the protections against discrimination assured them by section 504 and this part.

§§ 365.112–365.129 [Reserved]

§ 365.130 General prohibitions against discrimination.

(a) No qualified individual with handicaps shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

(b)(1) The agency, in providing any aid, benefit, or service may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap—

(i) Deny a qualified individual with handicaps the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with handicaps an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with handicaps with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aid, benefits, or service to individuals with handicaps or to any class of individuals with handicaps than is provided to others unless such action is necessary to provide qualified individuals with handicaps with aid, benefits, or services that are as effective as those provided to others.

(v) Deny a qualified individual with handicaps the opportunity to participate as a member of planning or advisory boards; or

(vi) Otherwise limit a qualified individual with handicaps in the enjoyment of any right, privilege, advantage or opportunity enjoyed by others receiving benefits under any programs administered by the Board.

(2) The agency may not deny a qualified individual with handicaps the opportunity to participate in programs or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) The agency may not, directly or through contractual or other arrangements, utilize criteria or methods of administration the purposes or effect of which would:

(i) Subject qualified individuals with handicaps to discrimination on the basis of handicap;

(ii) Deny qualified individuals with handicap assistance in obtaining benefits under any program administered by the agency; or

(iii) Defeat or substantially impair accomplishment of the objectives of a program or activity with respect to individuals with handicaps.

(4) The agency may not, in determining the site or location of a facility, make selections the purpose or effect of which would:

(i) Exclude individuals with handicaps from, deny them the benefits of, or otherwise subject them to discrimination under any program or activity conducted by the agency; or

(ii) Defeat or substantially impair the accomplishment of the objectives

of a program or activity with respect to individuals with handicaps.

(5) The agency, in the selection of procurement contractors, may not use criteria that subject qualified individuals with handicaps to discrimination on the basis of handicap.

(c) The exclusion of nonhandicapped persons from the benefits of a program limited by Federal statute or Executive Order to individuals with handicaps or the exclusion of a specific class of individuals with handicaps from a program limited by Federal statute or Executive Order to a different class of individuals with handicaps is not prohibited by this part.

(d) The agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with handicaps.

§§ 365.131–365.139 [Reserved]

§ 365.140 Employment.

No qualified individual with handicaps shall, on the basis of handicap, be subjected to discrimination in employment under any program or activity conducted by the agency. The definitions, requirements and procedures of section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791), as established by the Equal Employment Opportunity Commission in 29 CFR part 1613, shall apply to employment in federally conducted programs or activities.

§§ 365.141–365.148 [Reserved]

§ 365.149 Program accessibility: Discrimination prohibited.

Except as otherwise provided in § 365.150, no qualified individual with handicaps shall, because the agency's facilities are inaccessible to or unusable by individuals with handicaps, be denied the benefits of, be excluded from participation in, or otherwise be subjected to discrimination under any program or activity conducted by the agency.

§ 365.150 Program accessibility: Existing facilities.

(a) *General.* The agency shall operate each program or activity so that the program or activity when viewed in its entirety is readily accessible to and usable by individuals with handicaps. Although all facilities in which the agency operates, except for the headquarters building, are either owned or leased by and under the general control of the General Services Administration (GSA), the agency recognizes its obligation to request the GSA to make space reassignments or any structural changes which the agency determines are necessary to ensure program accessibility. This paragraph does not—

(1) Necessarily require the agency to make each of its existing facilities accessible to and usable by individuals with handicaps; or

(2) Require the agency to take or to recommend to the GSA any action that the agency can demonstrate would result in a fundamental alteration in the nature of a program or activity or result in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 365.150(a) would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the Chief Executive Officer after considering all agency resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens that would nevertheless ensure that individuals with handicaps receive the benefits and services of the program or activity.

(b) *Methods.* In general the agency will comply with this section by making home visits. The agency may also comply with the requirements of this section through such means as redesign of equipment, reassignment of services to accessible buildings, assignment of aids to beneficiaries, delivery of services at alternate accessible sites, alteration of existing facilities and construction of new facilities, use of accessible rolling stock, or any other methods that result in making its programs

or activities readily accessible to and usable by individuals with handicaps. The agency is not required to make or request the GSA to make structural changes in existing facilities where other methods are effective in achieving compliance with this section. The agency, in making or requesting space reassignments or alterations to existing buildings, shall ensure that accessibility requirements, to the extent compelled by the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), and any regulations implementing it are met. In choosing among available methods for meeting the requirements of this section, the agency shall give priority to those methods that offer programs and activities to qualified individuals with handicaps in the most integrated setting appropriate.

(c) *Time period for compliance.* The agency shall comply with the obligations established under this section by February 27, 1989, except that where structural changes in facilities are undertaken, the agency will make such changes or, where applicable, request the GSA to make such changes by December 27, 1991, but in any event as expeditiously as possible.

(d) *Transition plan.* In the event that structural changes to facilities will be undertaken to achieve program accessibility, the agency shall develop or, where applicable, request the GSA to develop, by June 27, 1989, a transition plan setting forth the steps necessary to complete such changes. The agency shall provide an opportunity to interested persons, including individuals with handicaps or organizations representing individuals with handicaps, to participate in the development of the transition plan by submitting comments (both oral and written). A copy of the transition plan shall be made available for public inspection. The plan shall, at a minimum—

(1) Identify physical obstacles in the agency's facilities that limit the accessibility of its programs or activities to individuals with handicaps;

(2) Describe in detail the methods that will be used to make the facilities accessible;

(3) Specify the schedule for taking the steps necessary to achieve compliance with this section and, if the time period of the transition plan is longer than one year, identify steps that will be taken during each year of the transition period; and

(4) Indicate the official responsible for implementation of the plan.

§ 365.151 Program accessibility: New construction and alterations.

Each building or part of a building that is constructed or altered by, on behalf of, or for the use of the agency shall be designed, constructed, or altered so as to be readily accessible to and usable by individuals with handicaps. The definitions, requirements, and standards of the Architectural Barriers Act (42 U.S.C. 4151–4157), as established in 41 CFR 101–19.600 to 101–19.607, apply to buildings covered by this section.

§§ 365.152–365.159 [Reserved]

§ 365.160 Communications.

(a) The agency shall take appropriate steps to ensure effective communication with applicants, participants, personnel of other Federal entities, and members of the public.

(1) The agency shall furnish appropriate auxiliary aids where necessary to afford an individual with handicaps an equal opportunity to participate in, and enjoy the benefits of, a program or activity conducted by the agency.

(i) In determining what type of auxiliary aid is necessary, the agency shall give primary consideration to the requests of the individual with handicaps.

(ii) The agency need not provide individually prescribed devices, readers for personal use or study, or other devices of a personal nature.

(2) Where the agency communicates with applicants and beneficiaries by telephone, telecommunication devices for deaf persons (TDD's) or equally effective telecommunication systems shall be used to communicate with persons with impaired hearing.

(b) The agency shall take appropriate steps to provide individuals with handicaps with information as to the existence and location of accessible services, activities, and facilities and information regarding their section 504

rights under the agency's programs or activities.

(c) This section does not require the agency to take any action that it can demonstrate would result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens. In those circumstances where agency personnel believe that the proposed action would fundamentally alter the program or activity or would result in undue financial and administrative burdens, the agency has the burden of proving that compliance with § 365.160 would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the Chief Executive Officer after considering all agency resources available for use in the funding and operation of the conducted program or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action required to comply with this section would result in such an alteration or such burdens, the agency shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with handicaps receive the benefits and services of the program or activity.

§§ 365.161–365.169 [Reserved]

§ 365.170 Compliance procedures.

(a) Except as provided in paragraph (b) of this section, this section applies to all allegations of discrimination on the basis of handicap in programs or activities conducted by the agency;

(b) The agency shall process complaints alleging violations of section 504 with respect to employment according to the procedures established by the Equal Employment Opportunity Commission in 29 CFR part 1613 pursuant to section 501 of the Rehabilitation Act of 1973 (29 U.S.C. 791).

(c) Except with respect to complaints arising under § 365.170(b), responsibility for implementation and operation of this section shall be vested in the Chief Executive Officer.

(d) The Chief Executive Officer shall accept and investigate all complete complaints for which he or she has jurisdiction. All complete complaints must be filed within 90 days of the alleged act of discrimination. The Chief Executive Officer may extend this time period for good cause.

(e) If the Chief Executive Officer receives a complaint over which the agency does not have jurisdiction, he or she shall promptly notify the complainant and shall make reasonable efforts to refer the complaint to the appropriate government entity.

(f) The Chief Executive Officer shall notify the Architectural and Transportation Barriers Compliance Board upon receipt of any complaint alleging that a building or facility used by the agency that is subject to the Architectural Barriers Act of 1968, as amended (42 U.S.C. 4151–4157), is not readily accessible to and usable by individuals with handicaps.

(g) Within 120 days of the receipt of a complete complaint under § 365.170(d) for which the agency has jurisdiction, the Chief Executive Officer shall notify the complainant of the results of the investigation in a letter containing—

(1) Findings of fact and conclusions of law;

(2) A description of a remedy for each violation found; and

(3) A notice of the right to appeal.

(h) Appeals of the findings of fact and conclusions of law or remedies must be filed by the complainant within 45 days of receipt from the Chief Executive Officer of the letter required by § 365.170(g). The Chief Executive Officer may extend this time for good cause.

(i) Timely appeals shall be accepted and processed by the Board.

(j) The Board shall notify the complainant of the results of the appeal within 60 days of the receipt of the request. If the Board determines that it needs additional information from the complainant, it shall have 30 days from the date it receives the additional information to make its determination on the appeal.

(k) The time limits cited in paragraphs (g) and (j) of this section may be extended with the permission of the Assistant Attorney General.

(l) The agency may delegate its authority for conducting complaint investigations to other Federal agencies

except that the authority for making the final determination may not be delegated to another agency.

§§ 365.171–365.999 [Reserved]

PART 366—COLLECTION OF DEBTS BY FEDERAL TAX REFUND OFFSET

Sec.

366.1 Notification to Internal Revenue Service.
366.2 Past-due legally enforceable debt.
366.3 Reasonable attempt to notify.
366.4 Notification to debtor.
366.5 Consideration of evidence.
366.6 Change in notification to Internal Revenue Service.

AUTHORITY: 45 U.S.C. 231f(b)(5); 31 U.S.C. 3720A.

SOURCE: 54 FR 397, Jan. 6, 1989, unless otherwise noted.

§ 366.1 Notification to Internal Revenue Service.

Upon entering into an agreement with the Internal Revenue Service and the Financial Management Service with regard to its participation in the tax refund offset program, the Board may notify the Internal Revenue Service, pursuant to the terms of such agreement, of past-due legally enforceable debts owed to the Board that are to be collected by tax refund offset. The Board's notification to the Internal Revenue Service will be as prescribed by the Internal Revenue Service in regard to information included and format, and will be made by such dates as prescribed by the Internal Revenue Service. The Board will provide the Internal Revenue Service with a toll-free or collect telephone number which the Internal Revenue Service may furnish to debtors whose refunds have been offset for use in obtaining information from the Board concerning the offset.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

§ 366.2 Past-due legally enforceable debt.

A past-due legally enforceable debt which may be referred to the Internal Revenue Service is a debt:

(a) Which arose under any statute administered by the Board or under any contract;

(b) Which is an obligation of a debtor who is a natural person or a business;

(c) Which, except in the case of a judgment debt, has been delinquent at least three months but not more than ten years at the time the offset is made;

(d) Which is at least $25.00;

(e) With respect to which the rights regarding reconsideration, waiver, and appeal, described in part 260 or 320 of this chapter or in other law, if applicable, have been exhausted;

(f) With respect to which either:

(1) The Board's records do not contain evidence that the debtor (or, if an individual, his or her spouse) has filed for bankruptcy under title 11 of the United States Code; or

(2) The Board can clearly establish at the time of the referral that the automatic stay under section 362 of the Bankruptcy Code has been lifted or is no longer in effect with respect to the debtor (or, if an individual, his or her spouse) and the debt was not discharged in the bankruptcy proceeding;

(g) Which cannot currently be collected pursuant to the salary offset provisions of 5 U.S.C. 5514(a)(1);

(h) Which is not eligible for administrative offset under 31 U.S.C. 3716(a) by reason of 31 U.S.C. 3716(c)(2), or cannot currently be collected by administrative offset under 31 U.S.C. 3716(a) by the Board against amounts payable to the debtor by the Board;

(i) Which cannot currently be collected by administrative offset under § 255.6 or § 340.6 of this chapter against amounts payable to the debtor under any statute administered by the Board;

(j) With respect to which the Board has notified, or has made a reasonable attempt to notify, the debtor that the debt is past due, and that unless the debtor repays the debt within 60 days, will be referred to the Internal Revenue Service for offset against any overpayment of tax; and

(k) With respect to which the Board has given the debtor at least 60 days from the date of the notification required in paragraph (j) of this section to present evidence that all or part of

the debt is not past due or legally enforceable, has considered evidence, if any, presented by such debtor, and has determined that an amount of such debt is past due and legally enforceable.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

§ 366.3 Reasonable attempt to notify.

In order to constitute a reasonable attempt to notify the debtor the Board must have used a mailing address for the debtor obtained from the Internal Revenue Service pursuant to section 6103 (m)(2) or (m)(4) of the Internal Revenue Code within a period of one year preceding the attempt to notify the debtor, whether or not the Board has used any other address maintained by the Board for the debtor.

§ 366.4 Notification to debtor.

The notification provided by the Board to the debtor will inform the debtor how he or she may present evidence to the Board that all or part of the debt is not past due or legally enforceable.

§ 366.5 Consideration of evidence.

Evidence submitted by the debtor will be considered only by officials or employees of the Board and a determination that an amount of such debt is past-due and legally enforceable will be made only by such officials or employees.

§ 366.6 Change in notification to Internal Revenue Service.

If, after submitting to the Internal Revenue Service notification of liability for a debt, the Board:

(a) Determines that an error has been made with respect to the information contained in the notification,

(b) Receives a payment or credits a payment to the account of the debtor named in the notification that reduces the amount of the debt referred to the Internal Revenue Service for offset, or

(c) Receives notification that the debtor has filed for bankruptcy under title 11 of the United States Code or has been adjudicated bankrupt and the debt has been discharged, the Board will promptly notify the Internal Revenue Service. However, the Board will make no notification to the Internal Revenue Service to increase the amount of a debt owed by a debtor named in the Board's original notification to the Internal Revenue Service. If the amount of a debt is reduced after referral by the Board and offset by the Internal Revenue Service, the Board will refund to the debtor any excess amount and will promptly notify the Internal Revenue Service of any refund made by the Board.

[54 FR 397, Jan. 6, 1989, as amended at 60 FR 66073, Dec. 21, 1995]

PART 367—RECOVERY OF DEBTS OWED TO THE UNITED STATES GOVERNMENT BY ADMINISTRATIVE OFFSET

Sec.

367.1 Purpose and scope.
367.2 Past-due legally enforceable debt.
367.3 Board responsibilities.
367.4 Notification to another agency.
367.5 Notification to debtor.
367.6 Consideration of evidence.
367.7 Change in notification to another government agency.
367.8 Administrative offset against amounts payable from Civil Service Retirement and Disability Fund.

AUTHORITY: 45 U.S.C. 231f(b)(5); 31 U.S.C. 3716.

SOURCE: 56 FR 46375, Sept. 12, 1991, unless otherwise noted.

§ 367.1 Purpose and scope.

The regulations in this part establish procedures to implement the Debt Collection Act of 1982 (Pub. L. 97–365), as amended by the Debt Collection Improvement Act of 1996 (Pub. L. 104–134), 31 U.S.C. 3716. The statute authorizes the Board to collect a claim arising under an agency program by means of administrative offset, and requires the Board to refer nontax debts over 180 days delinquent to the Department of Treasury for administrative offset (the ''Treasury Offset Program''). No claim may be collected by such means if outstanding for more than 10 years after the Board's right to collection of the debt first accrued, unless facts material to the Government's right to collect the debt were not known and could not reasonably have been known by the official or officials of the government

who were charged with the responsibility to discover and collect such debts. This part specifies the agency procedures that will be followed by the Board for referral and collection by administrative offset.

[62 FR 19220, Apr. 21, 1997]

§ 367.2 Past-due legally enforceable debt.

A past-due legally enforceable debt which may be referred to another governmental agency for administrative offset is a debt:

(a) Which arose under any statute administered by the Board or under any contract; and with respect to debts referred to the Department of Treasury, is a nontax debt;

(b) Which is an obligation of a debtor who is a natural person or a business;

(c) Which, except in the case of a judgment debt, has been delinquent at least three months but not more than ten years at the time the offset is made;

(d) Which is at least $25.00;

(e) With respect to which the rights described in part 260 or 320 of this chapter or the applicable law regarding reconsideration, waiver, and appeal, if applicable, have been exhausted;

(f) With respect to which:

(1) The Board's records do not contain evidence that the debtor (or, if an individual, his or her spouse) has filed for bankruptcy under title 11 of the United States Code; or

(2) The Board can clearly establish at the time of the referral that the automatic stay under section 362 of the Bankruptcy Code has been lifted or is no longer in effect with respect to the debtor (or, if an individual, his or her spouse) and the debt was not discharged in the bankruptcy proceeding; or

(3) The Board's records do not contain evidence that foreclosure is pending on collateral securing the debt.

(g) Which cannot currently be collected pursuant to the salary offset provisions of 5 U.S.C. 5514(a)(1);

(h) Which cannot currently be collected by administrative offset under § 255.6 or § 340.6 of this chapter against amounts payable to the debtor under any statute administered by the Board;

(i) With respect to which the Board has notified, or has made a reasonable attempt to notify, the debtor that the debt is past due, and that unless the debtor repays the debt within 60 days, the debt will be referred to any other agency of the United States government for offset against any money owed the debtor by that agency; and

(j) With respect to which the Board has given the debtor at least 60 days from the date of the notification required in paragraph (i) of this section to present evidence that all or part of the debt is not past due or legally enforceable, has considered evidence, if any, presented by the debtor, and has determined that the amount of such debt is past due and legally enforceable; and

(k) Which has not been referred to the Department of Justice or which is not otherwise in litigation with the Board.

[56 FR 46375, Sept. 12, 1991, as amended at 60 FR 66073, Dec. 21, 1995; 62 FR 19220, Apr. 21, 1997]

§ 367.3 Board responsibilities.

(a) The Board may delegate to an employee or employees the responsibility for collecting any claims owed the Board by means of administrative offset, except that all nontax debts over 180 days delinquent shall be referred to the Department of Treasury for administrative offset through the Treasury Offset Program as required by 31 U.S.C. 3716;

(b) Except for mandatory referral of claims to the Department of Treasury or as otherwise directed by the Secretary of Treasury, before collecting a claim by means of administrative offset, the Board must ensure that administrative offset is feasible, allowable, and appropriate, and must notify the debtor of the Board's policies for collecting a claim by means of administrative offset.

(c) Except for mandatory referral of claims to the Department of Treasury or as otherwise directed by the Secretary of Treasury, whether collection by administrative offset is feasible is a determination to be made on a case-by-case basis, in the exercise of its sound discretion. The Board shall consider not only whether administrative offset

can be accomplished, both practically and legally, but also whether offset is best suited to further and protect all of the Government's interests. In appropriate circumstances, the Board may give due consideration to the debtor's financial condition, and is not required to use offset in every instance in which there is an available source of funds. The Board may also consider whether offset would substantially interfere with or defeat the purposes of the program authorizing the payments against which offset is contemplated.

(d) Before advising the debtor that the delinquent debt will be subject to administrative offset, the agency official responsible for administering the program under which the debt arose shall review the claim and determine that the debt is valid and overdue.

(e) Administrative offset shall be considered by the Board only after attempting to collect a claim under the statutes administered by the Board except that no claim under this Act that has been outstanding for more than 10 years after the Government's right to collect the debt first accrued may be collected by means of administrative offset, unless facts material to the right to collect the debt were not known and could not reasonably have been known by the official of the agency who was charged with the responsibility to discover and collect such debts.

[56 FR 46375, Sept. 12, 1991, as amended at 62 FR 19220, Apr. 21, 1997.]

§ 367.4 Notification to another agency.

When the Board refers a debt under this part to another agency forcollection by means of administrative offset, the Board shall provide a written certification to the other agency stating that the debtor owes the debt (including the amount) and that the provisions of this part have been fully complied with.

§ 367.5 Notification to debtor.

The notification provided by the Board to the debtor will inform the debtor how he or she may present evidence to the Board that all or part of the debt is not past due or legally enforceable.

§ 367.6 Consideration of evidence.

Evidence submitted by the debtor will be considered only by officials or employees of the Board, and a determination that all or a portion of such debt is past-due and legally enforceable will be made only by such officials or employees.

§ 367.7 Change in notification to another government agency.

If, after submitting notification of liability for a debt to another agency, the Board:

(a) Determines that an error has been made with respect to the information contained in the notification;

(b) Receives a payment or credits a payment to the account of the debtor named in the notification that reduces the amount of the debt referred to the other agency for offset; or

(c) Receives notification that the debtor has filed for bankruptcy under title 11 of the United States Code or has been adjudicated bankrupt and the debt has been discharged; the Board will promptly notify the other agency. If the amount of a debt is reduced after referral by the Board and offset by the other agency, the Board will refund to the debtor any excess amount and will promptly notify the other agency of any refund made by the Board. If the amount of debt has increased after referral by the Board but prior to offset by the other agency, then the Board will promptly notify the other agency of such increase.

[56 FR 46375, Sept. 12, 1991, as amended at 60 FR 66073, Dec. 21, 1995]

§ 367.8 Administrative offset against amounts payable from Civil Service Retirement and Disability Fund.

(a) The Board may request that moneys which are due and payable to a debtor from the Civil Service Retirement and Disability Fund be administratively offset in reasonable amounts in order to collect debts owed to the Board by the debtor. Such requests shall be made to the appropriate officials of the Office of Personnel Management in accordance with such regulations as may be prescribed by the Director of that Office.

(b) When making a request for administrative offset under paragraph (a)

of this section, the Board shall include a written certification that:

(1) The debtor owes the United States a debt, including the amount of the debt;

(2) The Board has complied with all applicable statutes, regulations, and procedures of the Office of Personnel Management; and

(3) The Board has complied with the requirements of the applicable provisions of the Federal Claims Collection Standards, the Railroad Retirement Act and the Railroad Unemployment Insurance Act including any required hearing or review.

(c) When the Board decides to request administrative offset under paragraph (a) of this section, it should make the request as soon as practical after completion of the applicable due process procedures in order that the Office of Personnel Management may identify and flag the debtor's account in anticipation of the time when the debtor becomes eligible and requests to receive payments from the Fund. This will satisfy any requirement that offset be initiated prior to expiration of the applicable statute of limitations. At such time as the debtor makes a claim for payments from the Fund, if at least a year has elapsed since the offset request was originally made, the debtor will be permitted to offer a satisfactory repayment plan in lieu of offset upon establishing that changed financial circumstances would render the offset unjust.

(d) In accordance with procedures established by the Office of Personnel Management, the Board may request an offset from the Civil Service Retirement and Disability Fund prior to completion of due process procedures.

(e) If the Board collects part or all of the debt by other means before deductions are made or completed pursuant to paragraph (a) of this section, the Board shall act promptly to modify or terminate its request for offset under paragraph (a) of this section.

PART 368—PROHIBITION OF CIGARETTE SALES TO MINORS

Sec.

368.1 Introduction.
368.2 Definitions.
368.3 Vending machines.
368.4 Concession stands.
368.5 Free tobacco samples.

AUTHORITY: Sec. 636, Pub. L. 104–52, 109 Stat. 507 (40 U.S.C. 486nt).

SOURCE: 61 FR 8214, Mar. 4, 1996, unless otherwise noted.

§ 368.1 Introduction.

This part implements Public Law 104–52, the ''Prohibition of Cigarette Sales to Minors in Federal Buildings and Lands Act,'' which prohibits the sale of tobacco products through vending machines and the distribution of free samples of tobacco products on Federal property.

§ 368.2 Definitions.

As used in this part—

Federal property includes any building and real property occupied and maintained by the Board.

Minor means an individual under the age of 18 years.

Tobacco product means cigarettes, cigars, little cigars, pipe tobacco, smokeless tobacco, snuff, and chewing tobacco.

§ 368.3 Vending machines.

The sale of tobacco products in vending machines is prohibited in or around Federal property occupied and maintained by the Railroad Retirement Board.

§ 368.4 Concession stands.

Tobacco products may be sold on property occupied and maintained by the Railroad Retirement Board only as authorized by the Railroad Retirement Board or the General Services Administration or other Federal agency. Concession stands may not sell tobacco products to minors.

§ 368.5 Free tobacco samples.

The distribution of free samples of tobacco products is prohibited in or around Federal property occupied and maintained by the Railroad Retirement Board.

PART 369—USE OF THE SEAL OF THE RAILROAD RETIREMENT BOARD

Sec.

369.1 Unofficial use of the seal of the Railroad Retirement Board.
369.2 Authority to grant written permission for use of the seal.
369.3 Procedures for obtaining permission to use the seal.
369.4 Inappropriate use of the seal.
369.5 Penalty for misuse of the seal.

AUTHORITY: 18 U.S.C. 701; 45 U.S.C. 231f.

SOURCE: 66 FR 29475, May 31, 2001, unless otherwise noted.

§ 369.1 Unofficial use of the seal of the Railroad Retirement Board.

Use of the seal of the Railroad Retirement Board for non-Agency business is prohibited unless permission for use of the seal has been obtained in accordance with this part.

§ 369.2 Authority to grant written permission for use of the seal.

The Board hereby delegates authority to grant written permission for the use of the seal of the Railroad Retirement Board to the Director of Administration.

§ 369.3 Procedures for obtaining permission to use the seal.

Requests for written permission to use the seal of the Railroad Retirement Board shall be in writing and shall be directed to the Director of Administration of the Railroad Retirement Board. The request should, at a minimum, contain the following information:

(a) Name and address of the requester.

(b) A description of the type of activity in which the requester is engaged or proposes to engage.

(c) A statement of whether the requester considers the proposed use or imitation to be commercial or non-commercial, and why.

(d) A brief description and illustration or sample of the proposed use, as well as a description of the product or service in connection with which it will be used. This description will provide sufficient detail to enable the Director of Administration to determine whether the intended use of the seal is consistent with the interests of the government.

(e) In the case of a non-commercial use, a description of the requesting organization's function and purpose shall be provided.

§ 369.4 Inappropriate use of the seal.

The Railroad Retirement Board shall not grant permission for use of the seal in those instances where use of the seal will give the unintended appearance of Agency endorsement or authentication. Situations where use of the seal of the Railroad Retirement Board would be inappropriate include, but are not limited to, the following examples:

(a) A consulting firm makes arrangements with a railroad to conduct a retirement planning seminar for its employees. Included in the material distributed to the seminar attendees is a booklet, prepared by the consulting firm, which displays the seal of the Railroad Retirement Board on the cover and contains information regarding benefits payable under the Railroad Retirement Act.

(b) A former employee of the Railroad Retirement Board owns a coffee and donut shop, frequented by present and past railroad workers. Many of the shop's customers know of the owner's prior employment with the Board and frequently ask him questions related to benefits payable under the Railroad Unemployment Insurance and Railroad Retirement Acts. The shop owner prepares and distributes to his customers a monthly flyer listing benefit questions presented to him during the month, as well as his answers to the questions. The flyer displays the seal of the Board.

(c) A retired railroad employee works part-time in a train hobby shop. The shop owner, at the former railroad worker's suggestion, develops and sells items such as coffee mugs and computer mouse pads with text relevant to benefits paid by the Railroad Retirement Board. The text is taken from publications issued by the Railroad Retirement Board. The merchandise also bears the seal of the Railroad Retirement Board.

§ 369.5 Penalty for misuse of the seal.

Unauthorized use of the seal of the Railroad Retirement Board may result in criminal prosecution under applicable law.

SUBCHAPTER G [RESERVED]

SUBCHAPTER H—EMERGENCY REGULATIONS

PART 375—PLAN OF OPERATION DURING A NATIONAL EMERGENCY

Sec.
375.1 Purpose.
375.2 National emergency and effective date.
375.3 Policy.
375.4 Mailing instructions.
375.5 Organization and functions of the Board, delegations of authority, and lines of succession.
375.6 Personnel, fiscal, and service functions.
375.7 Operating regulations.
375.8 Regulations for employers.

AUTHORITY: 45 U.S.C. 231f(b)(5), 362(l).

SOURCE: 29 FR 15864, Nov. 26, 1964, unless otherwise noted. Redesignated at 29 FR 16322, Dec. 5, 1964, and further redesignated at 45 FR 28314, Apr. 29, 1980.

§ 375.1 Purpose.

(a) The Railroad Retirement Board has adopted a plan to provide basic organization and methods of operation which may be needed to continue uninterrupted service during a period of national emergency as defined in § 375.2.

(b) The plan is published to inform all interested persons of the circumstances and ways in which the Board will organize and operate in a national emergency.

(c) For purposes of Government-wide uniformity, the procedures of the Board regarding payments during evacuation to employees and their dependents shall conform to those contained in subpart D of part 550 of the regulations of the Office of Personnel Management pertaining to ''Payments During Evacuation'' (5 CFR part 550, subpart D).

[29 FR 15864, Nov. 26, 1964, as amended at 64 FR 66381, Nov. 26, 1999]

§ 375.2 National emergency and effective date.

A period of national emergency shall be deemed to exist and the provisions of this part shall become effective only (a) after an attack upon the United States, or at a time specified by the authority of the President after such attack, and (b) by order of the Chair of the Board or his or her successor as set forth in § 375.5, or when it is no longer possible to communicate with such official at his or her designated station.

[29 FR 15864, Nov. 26, 1964, as amended at 64 FR 66381, Nov. 26, 1999]

§ 375.3 Policy.

To the greatest extent possible, payment of benefits shall be made and employment service functions shall be carried on through the period of a national emergency in strict conformance with the pertinent provisions of the Railroad Retirement Act, the Railroad Unemployment Insurance Act, and the regulations promulgated by the Board to administer those acts. Where the character of the national emergency is such as to prevent this, the stand-by regulations contained in this part shall obtain. It will be expected, however, that every effort shall be made to return to normal operating practices as quickly as possible thereafter.

§ 375.4 Mailing instructions.

In a national emergency as defined in § 375.2, all mail shall be directed to Board offices at their normal locations.

[40 FR 52844, Nov. 13, 1975]

§ 375.5 Organization and functions of the Board, delegations of authority, and lines of succession.

(a) During a national emergency, as defined in § 375.2, the respective functions and responsibilities of the Board shall be, to the extent possible, as set forth in the U.S. Government Manual, which is published annually by the Office of the Federal Register, and is available on the Internet at *http://www.nara.gov/fedreg/*, under *Other Publications*.

(b) The following delegation of authority is made to provide continuity in the event of a national emergency:

(1) The Chair of the Board shall act with full administrative authority for the Board.

(2) In the absence or incapacity of the Chair, the authority of the Chair to act

shall pass to the available successor highest on the following list:

Labor Member of the Board
Management Member of the Board
Director of Administration
Director of Programs
General Counsel
Chief Information Officer
Director of Supply and Service
Regional Directors in order of length of Board service.

(3) Except as may be determined otherwise by the Chair of the Board or his or her successor and as provided in §§ 375.6 and 375.7, the duties of each office head or regional director shall be discharged in his or her absence or incapacity during a national emergency by the available staff member next in line of succession. Each office head and each regional director shall designate and preposition the line of succession within his or her office or region. If no such designation has been made, such duties shall be assumed by the available subordinate who is highest in grade or, if there is more than one, in length of Board service.

(4) Emergency responsibility and authority under this section, once assumed, shall be relinquished on direction of the duly constituted higher authority acting under the provisions of paragraph (b)(2) of this section.

[Board Order 68–135, 29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 71–26, 36 FR 4980, Mar. 16, 1971; Board Order 75–52, 40 FR 26673, June 25, 1975; 40 FR 52844, Nov. 13, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.6 Personnel, fiscal, and service functions.

(a) *Personnel.* In a national emergency as defined in § 375.2, when it is no longer possible for a regional director to communicate with the Chair or his or her successor as set forth in § 375.5, complete responsibility and authority for administration of the personnel function are delegated to such regional director for his or her respective geographic area.

(b) *Fiscal.* (1) In a national emergency, as defined in § 375.2, the Chair of the Board or his or her successor, as set forth in § 375.5, shall designate an individual to assume the responsibilities of the Chief Financial Officer in the event that he or she is unable to assume those responsibilities.

(2) In a national emergency, incumbents of the following positions are hereby authorized to appoint emergency certifying officers:

Director of Administration
Director of Programs
Chief Financial Officer
Regional Directors.

(i) The emergency certifying officers shall be empowered to certify:

(*a*)Benefit payments under the Railroad Retirement Act.

(*b*)Benefit payments under the Railroad Unemployment Insurance Act.

(*c*)Administrative expenses of the Railroad Retirement Board.

(ii) Emergency certifying officers shall be appointed under the authority delegated by this section when (*a*) normal channels for certifying payments have been rendered inoperable, and (*b*) clearance has been obtained from the ranking offical in line of sucession as set forth in § 375.5(b)(1) and (2) and under such instructions and conditions as he may prescribe.

(c) *Supply and service.*(1) In a national emergency, as defined in § 375.2, complete responsibility and authority for the procurement of needed supplies, equipment, space, communications, transportation, and repair services, are delegated to each regional director for his or her geographic area.

(2) Federal sources of supply and service, if available, shall be used.

(3) Any supplies, equipment, space, or services provided under this emergency delegation shall be documented to show what was provided, the amount procured, the cost thereof, and the source from which procured.

(4) As soon after the period of national emergency as conditions permit, the records required by paragraph (c)(3) of this section shall be transmitted to the Director of Supply and Service or his surviving successor.

[29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 67–29, 32 FR 3975, Mar. 11, 1967; 34 FR 12490, July 31, 1969; Board Order 75–52, 40 FR 26674, June 25, 1975; 40 FR 52844, Nov. 13, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.7 Operating regulations.

(a) *Retirement claims.* (1) In a national emergency as defined in § 375.2, applications for and development and certification of claims for retirement, disability, and survivor benefits shall be to the extent possible, as set forth in subchapter B of this chapter, except that:

(i) Standards of evidence may be relaxed although legal requirements for entitlement to payments shall remain unchanged; in determining relationships, employment, birth, death, etc., consideration shall be given to whatever information is in the possession of applicants and beneficiaries or the Board office adjudicating a claim.

(ii) If prescribed forms are not available, any writing that contains substantially the necessary information shall be acceptable.

(iii) In a national emergency, that is when the headquarters office is inoperable, the development and certification of claims shall be assumed by the regional offices.

(2) To provide the necessary authority for a decentralized program as outlined in this paragraph (a), those authorities which have been delegated to the Director of Programs are hereby delegated to the regional directors or their surviving successors.

(b) *Unemployment and sickness claims.* (1) In a national emergency as defined in § 375.2, receipt, adjudication, and certification of claims for unemployment and sickness benefits shall be to the extent possible as set forth in subchapter C of this chapter, except that:

(i) Where the Board's wage records have been destroyed or are otherwise unavailable, the wage-record evidence in the possession of the claimant, or the employer's wage records will be acceptable in determining qualifications for benefits.

(ii) In the event normal record sources are destroyed or otherwise unavailable, other evidence of previous benefit payments shall be considered in determining the periods for which benefits are currently payable and the amounts.

(iii) In developing sickness benefit claims where medical evidence in the form of a doctor's statement is not available, an affidavit from the claimant or other person having knowledge of his sickness or injury shall be acceptable.

(iv) If prescribed forms are not available, any writing that contains substantially the necessary information shall be acceptable.

(v) Eligibility interviews, investigations, and checking procedures shall be curtailed.

(vi) If claims cannot be submitted to the processing offices in headquarters because of the national emergency, the development and certification of claims shall be assumed by district offices.

(2) To provide the necessary authority for a decentralized program as outlined in paragraph (b) of this section, the authorities which have been delegated to the Director of Programs and to the regional directors are hereby delegated to the district managers or to their surviving successors.

[29 FR 15864, Nov. 26, 1964. Redesignated at 29 FR 16322, Dec. 5, 1964, as amended by Board Order 75–52, 40 FR 26674, June 25, 1975; 64 FR 66381, Nov. 26, 1999]

§ 375.8 Regulations for employers.

(a) In a national emergency, as described in § 375.2, employers shall continue to follow, to the greatest extent possible, the requirements pertaining to employers in subchapters A, B, and C of this chapter.

(b) Where a national emergency, as described in § 375.2, prevents an employer from following any requirement imposed by paragraph (a) of this section, the employer shall comply with such requirement as soon as possible after the cessation of the national emergency.

(c) In a national emergency, as defined in § 375.2, all communications by employers shall be directed as set forth in § 375.4.

[64 FR 66382, Nov. 26, 1999]

SUBCHAPTER I [RESERVED]

FINDING AIDS

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For the period before January 1, 2001, see the ''List of CFR Sections Affected,'' 1949–1963, 1964–1972, 1973–1985, and 1986–2000, published in 11 separate volumes.

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1 Revised; interim 28961
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30 (Subchapter C) Added; interim 28962
Comment period reopened 47382

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217.8 (m) through (u) redesignated as (n) through (v); new (m) added 27454
369 Added 29475

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1 Revised 78885
30 (Subchapter C) Revised 78876
30.112 OMB number pending 78874
30.213 OMB number pending 78874

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200.1 (a)(4), (b)(1) and (2) revised 5723
200.7 (i) added 5723
217.9 (b)(1) amended; (b)(3) added 42714
217.30 (b) removed; (c) redesignated as (b); new (c) added 42714
260 Heading revised 77153
260.1 Heading and (a) introductory text revised; (b), (d)(1) and (2) amended 77153
260.2 Revised 77153

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260.3 Heading, (a), introductory text, (b), (c), (d) and (f) revised 77153
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260.5 Revised 77154
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260.9 (d) through (g) redesignated as (e) through (h); (b), new (e) and new (f) revised; new (d) added 77155
260.10 Revised 77156
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320.6 (b) introductory text, (d) and (e) revised; (b)(8) and (f) added 77156
320.10 (e) revised 77156
320.11 (a) and (f) revised; (d), (e), and (g) amended 77156
320.12 Revised 77157
320.25 (a), (b) and (d) revised 77157
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30.112 OMB number 14316
30.213 OMB number 14316

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200.4 (d), (h), (i) and (m) revised; (j) introductory text, (2), (k), (l), (n)(2) and (p) amended 61621
206 Added 51153
218.9 (a)(2) amended 39010
Regulation at 68 FR 39010 corrected 45315
218.12 (b)(2)(ii) amended 39010
Regulation at 68 FR 39010 corrected 45315
218.13 (b)(1)(ii) and (2)(ii) amended 39010
Regulation at 68 FR 39010 corrected 45315
218.16 (b)(2)(ii) amended 39010
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218.40 (c)(4) amended 39010
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218.43 (b)(3) and (c)(6) amended 39010
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218.44 (b)(3) and (c)(6) amended 39010
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220.110 (f) added 60291
220.112 (a) amended 60291
220.114 Revised 60291
220.120 Revised 60293
220.135 Added 60294
220.161 Amended 39010
220.176 Amended 39010
220 Appendix 2 amended 60294
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225.33 (a)(1) amended 39010
225.34 (a)(1) amended; (b)(3) revised; (b)(4) added 39010

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30 (Subchapter C) Revised 78534

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320.22 (a) amended; (c) revised 55283
320.25 (d) revised 55284
341.6 (a) introductory text revised 53005
341.8 (a) and (c) amended; (b) revised 53005

2007

(No regulations published from January 1, 2007, through April 1, 2007)