# Choosing your appeal route

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**Under the Federal Employees'** Compensation Act (FECA), an injured worker has the "burden of proof" for submitting the evidence to establish that a claim meets all five basic elements:

1. That the claim was timely filed.
2. That the injured worker is a civil employee.
3. Fact of injury—factual and medical.
4. That the injury occurred in the performance of duty.
5. That there is a causal relationship between the injury and work factors.

A formal decision is required in any case where one or more of the five basic elements of the claim has not been met. As a claim is being developed, injured workers must be provided an opportunity to perfect their claim. Before preparing an initial case denial, the Office of Workers' Compensation Programs (OWCP) must develop the claim and advise the injured worker in writing of their burden of proof in establishing entitlement to benefits.

A development letter will be issued, informing the injured worker of the deficiencies in the evidence submitted, the information necessary to correct them and the deadline for submitting the evidence and the consequences for failing to do so.

**After all appropriate development, if one of the five** basic elements has not been met, the case will be denied. A formal decision with appeal rights is sent to the injured worker, explaining the deficiencies in the claim.

OWCP reviews each of the five basic elements in order and will stop reviewing the claim file when one of the elements has not been met. In many cases, the fact of injury element is not met when the medical evidence does not have a valid diagnosis. In this instance, OWCP stops reviewing the claim file, the claim will be denied for fact of injury, and the performance of duty and causal relationship elements will not be reviewed.

Injured workers should read OWCP decisions carefully. After a review of the background of the claim and the evidence in the claim file, the decision usually has a few key sentences explaining the exact basis for the denial.

The specific deficiencies in basis for denial must be resolved for a successful appeal. In most cases, the claim is denied based on the lack of a doctor's explanation of the causal relationship between the diagnosed condition(s) and work factors. A medical report that satisfies the deficiencies noted in the denial letter will be needed for a successful appeal.

**The FECA provides four avenues of appeal. Each appeal** route has statutory time limits for when the appeal must be made.

An appeal to the Branch of Hearings and Review (BHR) for an oral hearing or review of the written record must be made within 30 days from the date of the decision. In many cases, this may be the best appeal route for initial denials. Hearings representatives at the BHR are highly experienced claims examiners.

The give and take in an oral hearing allows the injured worker to ask for and understand exactly what's needed to get the claim accepted. If the injured worker submits sufficient documentation for the claim to be accepted, the hearings representative can accept the claim without going to hearing. Reviews of the written record at the BHR have similar advantages.

All decisions by the BHR are merit decisions, entitling the injured worker appeal rights to reconsideration with the Employees' Compensation Appeals Board (ECAB).

The second avenue of appeal is to request reconsideration, which must be filed within one year of the date of the denial. While the one-year deadline is generous, injured workers should never wait that long to file an appeal. To receive a merit decision entitling further appeals, the request must be accompanied by relevant new evidence or argument not considered previously.

While no special form is required, the request must be in writing, and it must be signed and dated by the claimant or the authorized representative. The request should also identify the decision and the specific issue(s) for which reconsideration is being requested.

Requests for reconsideration are adjudicated by an OWCP quality assurance and mentoring examiner (QAM) or higher authority who was not involved in making the decision being appealed. All reconsideration decisions, whether affirmative or negative, must be issued by a QAM or higher authority.

**The final avenue of appeal is to the ECAB. The ECAB** will examine only the evidence in the claim file on the date of the decision. In most cases, an injured worker should not appeal an initial decision directly to the ECAB.

NALC workers' compensation specialists generally appeal to the ECAB in cases where previous decisions failed to sufficiently review medical evidence or points of law. NALC members are encouraged to contact their national business agent's office and request that a regional workers' compensation assistant review any denial prior to appealing to the ECAB.