

which could impact, either favorably or unfavorably, on future employability.

(5) A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the claimant has already reached maximum medical improvement, a medical report prepared at the time the employee's condition stabilized will satisfy the requirement for a current medical report. A medical report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.

(6) A statement explaining how the settlement amount is considered adequate.

(7) If the settlement application covers medical benefits an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment shall also be submitted which indicates the inflation factor and/or the discount rate used, if any. The adjudicator may waive these requirements for good cause.

(8) Information on any collateral source available for the payment of medical expenses.

(Approved by the Office of Management and Budget under control number 1215-0160)

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

**§ 702.243 Settlement application; how submitted, how approved, how disapproved, criteria.**

(a) When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they shall submit a complete application to the adjudicator. The application shall contain all the information outlined in § 702.242 and shall be sent by certified mail, return receipt requested or submitted in person, or by any other delivery service with proof of delivery to the adjudicator. Failure to submit a complete application shall toll the thirty day period mentioned in section 8(i) of the

Act, 33 U.S.C. 908(i), until a complete application is received.

(b) The adjudicator shall consider the settlement application within thirty days and either approve or disapprove the application. The liability of an employer/insurance carrier is not discharged until the settlement is specifically approved by a compensation order issued by the adjudicator. However, if the parties are represented by counsel, the settlement shall be deemed approved unless specifically disapproved within thirty days after receipt of a complete application. This thirty day period does not begin until all the information described in § 702.242 has been submitted. The adjudicator shall examine the settlement application within thirty days and shall immediately serve on all parties notice of any deficiency. This notice shall also indicate that the thirty day period will not commence until the deficiency is corrected.

(c) If the adjudicator disapproves a settlement application, the adjudicator shall serve on all parties a written statement or order containing the reasons for disapproval. This statement shall be served by certified mail within thirty days of receipt of a complete application (as described in § 702.242.) if the parties are represented by counsel. If the disapproval was made by a district director, any party to the settlement may request a hearing before an ALJ as provided in sections 8 and 19 of the Act, 33 U.S.C. 908 and 919, or an amended application may be submitted to the district director. If, following the hearing, the ALJ disapproves the settlement, the parties may: (1) Submit a new application, (2) file an appeal with the Benefits Review Board as provided in section 21 of the Act, 33 U.S.C. 921, or (3) proceed with a hearing on the merits of the claim. If the application is initially disapproved by an ALJ, the parties may (1) submit a new application or (2) proceed with a hearing on the merits of the claim.

(d) The parties may submit a settlement application solely for compensation, or solely for medical benefits or for compensation and medical benefits combined.

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(e) If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.

(f) When presented with a settlement, the adjudicator shall review the application and determine whether, considering all of the circumstances, including, where appropriate, the probability of success if the case were formally litigated, the amount is adequate. The criteria for determining the adequacy of the settlement application shall include, but not be limited to:

(1) The claimant's age, education and work history;

(2) The degree of the claimant's disability or impairment;

(3) The availability of the type of work the claimant can do;

(4) The cost and necessity of future medical treatment (where the settlement includes medical benefits).

(g) In cases being paid pursuant to a final compensation order, where no substantive issues are in dispute, a settlement amount which does not equal the present value of future compensation payments commuted, computed at the discount rate specified below, shall be considered inadequate unless the parties to the settlement show that the amount is adequate. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation shall be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which shall be updated from time to time. The discount rate shall be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52 weeks U.S. Treasury Bills settled immediately prior to the date of the submission of the settlement application.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 60 FR 51348, Oct. 2, 1995]

## 20 CFR Ch. VI (4-1-08 Edition)

### CONTROVERTED CLAIMS

#### § 702.251 Employer's controversion of the right to compensation.

Where the employer controverts the right to compensation after notice or knowledge of the injury or death, or after receipt of a written claim, he shall give notice thereof, stating the reasons for controverting the right to compensation, using the form prescribed by the Director. Such notice, or answer to the claim, shall be filed with the district director within 14 days from the date the employer receives notice or has knowledge of the injury or death. The original notice shall be sent to the district director having jurisdiction, and a copy thereof shall be given or mailed to the claimant.

(Approved by the Office of Management and Budget under control number 1215-0023)

(Pub. L. No. 96-511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984]

#### § 702.252 Action by district director upon receipt of notice of controversion.

Upon receiving the employer's notice of controversion, the district director shall forthwith commence proceedings for the adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

### CONTESTED CLAIMS

#### § 702.261 Claimant's contest of actions taken by employer or carrier with respect to the claim.

Where the claimant contests an action by the employer or carrier reducing, suspending, or terminating benefits, including medical care, he should immediately notify the office of the district director having jurisdiction, in person or in writing, and set forth the facts pertinent to his complaint.

#### § 702.262 Action by district director upon receipt of notice of contest.

Upon receipt of the claimant's notice of contest, the district director shall forthwith commence proceedings for adjudication of the claim in accordance with the procedures set forth in subpart C of this part.