

comment and the difference in the requirement to update an injury versus an occupational illness, since occupational illnesses become reportable on the date of diagnosis.

At the post-NPRM meeting, FRA explained that the requirements were not inconsistent. There is a difference between *monitoring* (for 180 days) an illness or injury about which the railroad had prior knowledge, or already reported or listed as an accountable, versus having to file a *late report* for injuries or illnesses that were *never reported in any form* but should have been. With respect to the cases being *monitored*, the five-year reporting obligation would only hold the railroad responsible for failing to report a change in an employee's illness or injury that occurred within the 180-day monitoring period. Thus, if a change occurred on the 180th day, and the railroad did not discover its error in failing to report until two years later, an obligation to file a late report would still exist, but if a change occurred on the 181st day, the railroad is no longer under an obligation to *actively monitor or investigate* the case and would not be held accountable for failing to report such a *change* one day, one year, or five years later. If a railroad is provided with information or documentation of consequences that the employee claims is related to an injury that occurred more than 180 days ago, the railroad would have to handle the injury as it would a new case.

#### Final Rule/Decision

FRA has adopted the 180-day cap as proposed. The new cap reflects Working Group agreement that reportable and accountable injuries are tracked for 180 days from the date of the incident. However, if an injury becomes reportable *during that monitoring/tracking period*, the carrier will report it when it becomes known, even after the 180 days. This approach differs slightly from OSHA's approach, which appears to require an employer to continue counting days until the 180-day maximum is reached, regardless of whether those days were consecutive or intermittent. Thus, an employer may have to monitor or track an injury for more than 180 days. In contrast, FRA's cap of 180 days will only be reached if the employee misses those days consecutively. It has generally been FRA's experience that a reportable injury will meet one or more of the general reportability criteria within the 180-day time frame and that only a few cases continue to result in missed days beyond this time frame. Additionally, this difference would not likely have a substantial effect on the data for

purposes of OSHA's severity index, since under that index 120 days away from work missed intermittently over a 180-day period would be comparable in severity to 180 days missed consecutively, or 180 days missed intermittently over a two-year period. Thus, FRA has concluded that the burden on the employer of having to monitor a case for as long a period as necessary to compile 180 days away from work outweighs the benefit of capturing more days in a few cases by adopting an intermittent 180-day cap.

FRA has added to the *2003 Guide* an explanation of the difference in occupational illness reporting versus injury and has clarified the discussion concerning the required time period for monitoring and how it relates to updating reports. FRA will address the differences in the 180-day cap in its MOU with OSHA.

#### 3. Definitions of "Medical Treatment" and "First Aid"

##### Proposal

FRA's *1997 Guide* indicated what constituted "medical treatment" and what constituted "first aid" and how to categorize other kinds of treatment. See *1997 Guide*, Ch. 6, pp. 6–9. As stated in the *1997 Guide*, "medical treatment" rendered an injury reportable. If an injury or illness required only "first aid," the injury was not reportable, but was, instead, accountable. Under OSHA's final rule, a list is provided of what constitutes "first aid." 29 CFR 1904.7(b)(5). If a particular procedure is not included on that list, and does not fit into one of the two categories of treatments that are expressly defined as not medical treatment (diagnostic procedures and visits for observation or counseling), then the procedure is considered to be "medical treatment." *Id.* FRA proposed to amend its regulations and *Guide* to conform to OSHA's definition and new method of categorizing what constitutes medical treatment and first aid. Specifically, FRA proposed to amend its regulations and the *Guide* to address the following four items:

a. *Counseling*. Under FRA's "definitions" section of its regulations,

\* \* \* Medical treatment also does not include preventive emotional trauma counseling provided by the railroad's employee counseling and assistance officer unless the participating worker has been diagnosed as having a mental disorder that was significantly caused or aggravated by an accident/incident and this condition requires a regimen of treatment to correct.

See § 225.5. In contrast, under OSHA's final rule, "medical treatment does not

include: (A) Visits to a physician or other licensed health care professional solely for observation or *counseling*. \* \* \* Emphasis added. See 29 CFR 1904.7(b)(5)(i). Accordingly, to conform to OSHA's final rule, FRA proposed to amend its definition of "medical treatment" to exclude counseling as a type of medical treatment. See proposed § 225.5.

b. *Eye patches, butterfly bandages, Steri-Strips™*, and similar items. Under FRA's *1997 Guide*, use of an eye patch, butterfly bandage, Steri-Strip™, or similar item was considered medical treatment, rendering the injury reportable. Under OSHA's final rule, however, use of an eye patch, butterfly bandage, or Steri-Strip™ is considered to be first aid and, therefore, not reportable. In order to conform FRA's *Guide* to OSHA's Final Rule, FRA proposed to amend the *Guide* so that use of an eye patch, butterfly bandage, or Steri-Strip™ would be considered first aid.

c. *Immobilization of a body part*. Under FRA's *1997 Guide*, immobilization of a body part for transport purposes was considered medical treatment. Given, however, that OSHA's final rule considers immobilization of a body part for transport to be first aid, FRA proposed to amend its *Guide* so that immobilization of a body part solely for purposes of transport would be considered first aid.

d. *Prescription versus non-prescription medication*. Under FRA's *1997 Guide*, a doctor's order to take over-the-counter medication was not considered medical treatment even if a doctor ordered a dosage of the over-the-counter medication at prescription strength. Under OSHA's final rule, however, a doctor's order to take over-the-counter medication at prescription strength is considered medical treatment rather than first aid. For example, under OSHA's final rule, if a doctor orders a patient to take simultaneously three 200 mg. tablets of over-the-counter Ibuprofen, this case would be reportable, since 467 mg. of Ibuprofen is considered to be prescription strength.

The Working Group struggled with this issue. On the one hand, it is a legitimate concern that reportability not be manipulated by encouraging occupational clinics to substitute a non-prescription medication when a prescription medication is indicated. That result, however, may be more humane than a circumstance in which the medical provider is wrongly encouraged not to order an appropriate dosage.